Retreat Registration with Health and Medical Release Form

Please check the box next to the retreat you are registering for.
Please mail registration form and retreat fee: CAMP IROQUOINA, 2341 CAMP ROAD, HALLSTEAD PA 18822.
Make checks payable to "His Camps Inc."

Please register early. If your registration form and retreat fee are mailed at least 10 days before the start of the retreat, there is a $15 discount. See the retreat pages for retreat descriptions and fees or call the camp at 570-967-2577.

☐ Pre-Teen Retreat ☐ Ladies Retreat ☐ Fall Teen Getaway ☐ Father/Son Retreat (will need more than 1)

☐ Junior High Retreat ☐ Senior High Retreat ☐ College & Career Retreat

☐ Men's Retreat ☐ Skeet Retreat ☐ Family Retreat (will need more than 1)

CAMP IROQUOINA HEALTH FORM AND MEDICAL RELEASE FORM

To be filled in by parent/guardian of minors or by adults themselves. For Fall, Winter, and Spring Retreat Season Only

Name _____ Gender _____ Age _____ Birth date _____/_____/_____

Parent/Guardian _____ Home Phone (_____)_____

Home Address _____ Cell Phone (_____)_____

Email Address _____ Work Phone (_____)_____

Emergency Contact (if parent/guardian cannot be reached), notify:

Name _____ Relationship _____

Address _____ Phone Number _(_____)_____

ALLERGIES: List all known allergies; describe the reaction and how the reaction is managed.

Medication allergies: _____ _____
_____ _____

Food Allergies: _____ _____
_____ _____

Other allergies (include insect stings, hay fever, asthma, animal dander, etc.):

_____ _____
_____ _____

Has camper ever been stung by a bee or wasp? _____Yes _____No

Medications (List all medications brought to camp. Continue on separate sheet if necessary.)

Medication	Dosage and Times taken each day	Reason for Taking

Dentist/Orthodontist _____ Phone Number _(_____)_____
Physician's Name _____Phone Number _(_____)_____
Do you carry family medical/hospital insurance? YES NO
Insurance Company_____ Policy and/or Group #_____
Insurance Company Address _____

This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed camp activities except as noted. **Authorization of Treatment:** In the event of an accident, injury, or sickness, I hereby give permission to the medical personnel selected by the camp director to order X-rays, routine tests, administer treatment and if necessary hospitalization for the above named person. I give my permission for the release of any records necessary for insurance purposes. I understand that every effort will be made to contact me; but in the event that I cannot be reached, I hereby give permission to the camp director (or a responsible staff member the director appoints) to act on my behalf.

Signature of Parent/Guardian or adult camper or staff member _____ Date _____

I understand and agree to abide with the restrictions placed on my camp activities.

Signature of camper _____ Date _____

Photo permission: I give permission for the use of any possible pictures that include my child to be placed anonymously on camp websites or brochures. Consent is implied if box is not checked. No: ☐