

Eagle River United Methodist Camp – Camper/CIT Application

Camper's Name: _____ Date of Birth: _____ Grade: _____

Mailing Address: _____
Address City State

Gender: _____ Have you attended camp before? _____

Parent/Guardian(s): _____

Contact #: _____ Email Address: _____

Emergency Contact: _____

Relation: _____ Emergency Contact #: _____

Adults Authorized To Pick Up Camper: _____

Church: _____ Denomination: _____

Siblings/Relatives At Camp: _____

I understand that photographs or videos taken of my camper are property of ERUMC and may be used for promotional purposes unless the Camp Deans are instructed otherwise by the parent or guardian. I also understand that use of cameras by campers will be addressed on a case by case basis.

Printed Camper Name

Camper Signature

Printed Parent/Guardian Name

Parent/Guardian Signature

The Counselors-In-Training (CITs) 2020 Retreat is an exciting event for any youth who wish to serve as CITs at the ERUMC Discovery Camp July 17-25, 2020. This event is for youth 14-17 years of age as of March 1, 2020.

Please e-mail your registration forms to manager@methodistcamp.org. CIT Registration Fee is \$25 can be paid when the CIT is dropped off at camp on March 13. Checks should be made out to Eagle River Methodist Camp or ERUMC. Scholarships are available upon request. No youth will be turned away for inability to pay.

For more information, contact Beth McEwen at 907-209-3502 or Triston Wasik at 907-223-1825.

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Camper's Name: _____ DOB: _____ Grade: _____

Insurance Information - Is the participant covered by family medical insurance? _____

If Yes, Indicate Carrier: _____ Group #: _____

Insured Name: _____ Policy #: _____

Allergy Information (Please list known allergy and reaction)

Food Allergy: _____

Medical Allergy: _____

Other (Include insect stings, asthma, etc): _____

Medication - Will the participant be bringing medication to the camp? _____

If yes, list medication (prescription AND over the counter) and instructions for taking medication.

Medications must be in original bottle and turned in to Health Care Manager/Nurse upon arrival

Contact Information

Camper's Doctor: _____ Doctor Phone: _____

History of Illnesses

Special Needs

Activities that should not be participated in due to medical reasons:

Parent/Guardian Authorization:

I understand that camp staff needs to know pertinent information about the camper's mental and physical health. Therefore, I have disclosed all information that could jeopardize the camper's health and safety or the safety of others. Failure to disclose information could require my child to be sent home from camp. I give permission to the camp to provide routine health care, administer prescribed and over-the-counter medications and seek emergency medical treatment including ordering x-rays and routine tests. I give permission to the camp to arrange necessary related transportation. I agree to the release of any records necessary for insurance purposes. In the event I cannot be reached (or cannot respond if an adult camper) in case of an emergency, I give permission to the physician(s) selected by the camp staff to secure and administer proper treatment, including hospitalization, for the above named person and to release information regarding said medical treatment to camp staff.

Printed Parent/Guardian Name

Parent/Guardian Signature