Application Form 2016

(please type or print)

OFFICE USE

CABIN	RECEIPT NO.	CCF Receipted Amt	Conf. Receipted Amt

Pick-up Person's Name

First Name _____ Last Name _____

Mailing Address _____
(Street Address) (City) (State) (Zip)

Phone: ( ) _____ ( ) _____ ( ) _____
(Home Phone) (Mother's Work or Cell Phone) (Father's Work or Cell Phone)

Sex: ❑ Male ❑ Female Age: _____

Birthday _____ / _____ / _____ Grade: _____

Social Security No. _____

We do support, and the applicant agrees to abide by all camp regulations.

_____ _____
(Parent's Signature) (Camper's Signature)

Basic Camp Fee ($250)	$_____
4 Day Camp ($180)	$_____
Leadership Training ($275)	$_____
Specialty Class Fee	$_____
Picture CD ($10)	$_____
Laundry Service *($10 per extra week)*	$_____
Store Money	$_____
TOTAL ENCLOSED:	$_____

Indicate Week(s) of Attendance

☐ **Adventurer**	(Ages 6-9)	June 26 – July 3	☐ **Junior 4**	(Ages 10-12)	July 24 – July 31
☐ **Junior 1**	(Ages 8-12)	July 3 – July 10	☐ **Tween**	(Ages 12-16)	July 31 – Aug 7
☐ **Junior 2**	(Ages 10-12)	July 10 – July 17	☐ **Family Camp**	_____	
☐ **Junior 3**	(Ages 10-12)	July 17 – July 24			

Specialty Class Pre-Registration

Please indicate 1st, 2nd, 3rd choice for Junior-Tween camps, *Adventurer Camp:
(each class needs a minimum of 15 campers)

- ☐ **Water Skiing** ($125) *(Jr. 4)*
- ☐ **Wake Boarding** ($125) *(Tween)*
- ☐ **Ceramics** ($55)
- ☐ **Horsemanship** ($80) *(ages 10 & up)*
- ☐ **Backpacking** ($20) *(Jr. 4)*
- ☐ **Balloon Art*** ($15)
- ☐ **Optical Illusion*** ($10)
- ☐ **Guitar Lessons*** ($10)
- ☐ **Art Class** ($10)

Camp Cedar Falls Medical Consent Form

We, the undersigned parent(s) or guardian of:
Name of camper_____
a minor, do hereby consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital service that may be rendered to said minor under the general or special instructions of any physician the camp may call, whether such diagnosis or treatment is rendered at the office of said physician or at a licensed hospital.

It is further understood that this consent is given in advance of any specific diagnosis or treatment which might be required and is given to authorize Camp Cedar Falls or the physician to exercise their best judgment as to the requirements of such diagnosis or treatment.

This consent shall remain in continuous effect until revoked in writing and delivered to Camp Cedar Falls.

We hereby authorize any hospital, physician or other person who has attended or examined the minor to furnish the camp's insurance company or its representative, any and all information with respect to any illness, medical history, consultation, prescriptions or treatment and copies of all hospital or medical records. A photocopy of this authorization shall be considered as effective and valid as the original.

If your child has special needs, behavioral problems, or mental disorders, prior arrangements need to be made with camp director.

_____ _____
Parent or legal guardian's signature *Print Name*

Health record of_____
Date _____

1. Circle the number of times camper has been to camp.
   0 1 2 3 4 +
2. Check if applicant has:
   - ❑ Heart Trouble ❑ Lung Problem ❑ Seizures
   - ❑ Asthma ❑ Hypoglycemia ❑ High Blood Pressure
   - ❑ Headaches ❑ Diabetes ❑ Allergy to bee/wasp stings
3. Date of last tetanus if child over 12 years old: _____ .
4. Recent operation or injury: _____
5. Serious illness during past year: _____
6. Allergies: _____
7. Allergic to the following medication(s):
   _____
8. Non-Prescription medication may be taken at camp: ❑ Yes ❑ No
9. Medication taken within the year: _____
10. If more space is needed for explanations, attach separate sheet.

Please make checks payable to: Southern California Conference • Send to: Youth Ministries Dept. P.O. Box 969, Glendale, CA 91209
After June 16 send application to: Camp Cedar Falls, 39850 State Hwy 38, Angelus Oaks, CA 92305