Calvary Baptist Church,



320 Lincoln Street

Rhinelander WI 54501 715-362-4792 calvary@newnorth.net explorecalvary.com

**Home Address**



|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | *Address* | *City* |  |  | *State* | *Zip* |  |
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|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  |  | **Parent/Guardian Information** | |  |  |
|  |  | *Relationship* | *Home* | *Cell* | *Email* |
| *Last Name* | *First Name* | *to Child(ren)* | *Phone* | *Phone* | *Address* |
|  |  |  |  |  |  |
|  |  |  |  |  |  |



**Alternative Contacts If Parent/Guardian Cannot Be Reached** –Only those listed are authorized to pick up child(ren)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  |  | *Relationship* | *Home* | *Cell* |  |
|  | *Name* | *to Child(ren)* | *Phone* | *Phone* |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Child 1** | **Child(ren) Information** *(please complete all information)* | | |
|  | **Last Name:** |  | **First Name:** | **Birthday (mm/dd/yy):** |
|  |  |  |  |  |

**Allergies/Medical:**

**Medication (any medication must be in original container)**

**Special Concerns/Needs:**

|  |  |
| --- | --- |
| **Family Doctor:** | **Office Phone:** |
|  |  |

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|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Child 2** | **Child(ren) Information** *(please complete all information)* | | |  |
|  | **Last Name:** |  | **First Name:** | **Birthday (mm/dd/yy):** |  |
|  |  |  |  |  |  |
|  | **Allergies/Medical:** |  |  |  |  |

**Medication (any medication must be in original container)**

**Special Concerns/Needs:**

|  |  |
| --- | --- |
| **Family Doctor:** | **Office Phone:** |
|  |  |

* I give permission for my child to participate in activities at Calvary Baptist Church, Rhinelander WI. Activities may include walks and videos. I understand that Camp Calvary is a church-based program. I understand that my child must be picked up by 3:30pm. I authorize the volunteers and staff to administer emergency medical first aid treatment or to call for emergency medical response.

|  |  |  |  |
| --- | --- | --- | --- |
| Signature of Parent or Legal Guardian | |  | Date |
| Insurance Co: |  | Insurance # |  |

* I give my permission for my child to be photographed or videotaped. I understand that the image may be displayed in church publications, church buildings or website. I understand that as a precaution my child’s name will not be published or linked with photographs.

Signature of Parent or Legal Guardian Date

**Camp Calvary will operate from 8:00am to 3:30pm on October 14& October 25, November 15, December 13, January 24, February 21, April 25 and May 16. Some activities will be outdoors; please make sure your child is dressed appropriately for the weather. Please send a lunch with your child(ren). Snacks will be provided.**

**Registration forms are due back no later than October 9.**

*Pickup after 3:30 without notification will result in elimination from program. Please do not drop off children prior to 7:45 am.*