



Please return completed form **within ten days** of registration to:
 Lubbock Christian University Summer Camps
 5601 19th Street, Lubbock, TX 79407
Phone: (806) 720-7217 • **Fax:** (806) 720-7808
 Questions: Contact Terri Warren at terri.warren@lcu.edu

LCU Summer Camps Additional Registration

Thank you for registering for LCU Summer Camps! Your registration process is not complete until you have mailed in this completed form. Please return within 10 days of registration. This information will be used to identify participants and is confidential.

Camper Name: _____ Gender: _____ Birthday: _____

Camp (*circle one*): Encounter Camp Champion

Parent or guardian _____ Phone _____

Emergency Contact _____ Phone _____

Please attach
a recent
Wallet-sized **photo** here.

Please attach a copy of your
Insurance card here.

PARENT/GUARDIAN SIGNATURE REQUIRED FOR ENROLLMENT

I APPROVE THIS APPLICATION AND THE CONDITIONS LISTED HERE AND ON THE REGISTRATION WEBSITE, AND I HEREBY CERTIFY THAT MY CHILD IS WILLING AND ABLE TO ADHERE TO THE CAMPER GUIDELINES. IN THE EVENT THAT I CANNOT BE REACHED IN AN EMERGENCY, I HEREBY GIVE PERMISSION TO THE PHYSICIAN SELECTED BY THE CAMP DIRECTOR TO HOSPITALIZE, SECURE PROPER TREATMENT FOR, AND TO ORDER INJECTIONS, ANESTHESIA OR SURGERY FOR MY CHILD. I GRANT PERMISSION FOR MY CHILD TO PARTICIPATE IN **EVERY** ACTIVITY OFFERED AT CAMP. I UNDERSTAND THAT AS A PARTICIPANT, MY CHILD MAY BE PHOTOGRAPHED OR VIDEOTAPED DURING NORMAL ACTIVITIES, AND THESE PHOTOS/VIDEOS MAY BE USED IN PROMOTIONAL MATERIALS OR OTHER PUBLICATIONS INCLUDING THE CAMP WEBSITE. I ALSO UNDERSTAND AN ADDRESS BOOK IS PUBLISHED AT THE CONCLUSION OF EACH CAMP SESSION THAT WILL INCLUDE MY CHILD'S NAME AND ADDRESS.

MEDICAL RELEASE

THE HEALTH HISTORY STATED ONLINE OR ON THE ENROLLMENT FORM IS CORRECT AS FAR AS I KNOW, AND THE PERSON HEREIN DESCRIBED HAS PERMISSION TO ENGAGE IN ALL PRESCRIBED CAMP ACTIVITIES, EXCEPT AS NOTED. AUTHORIZATION FOR TREATMENT: I HEREBY GIVE PERMISSION TO THE MEDICAL PERSONNEL SELECTED BY THE CAMP DIRECTOR TO ORDER X-RAYS, ROUTINE TESTS, OR TREATMENT; TO RELEASE ANY RECORDS NECESSARY FOR INSURANCE PURPOSES; AND TO PROVIDE OR ARRANGE NECESSARY RELATED TRANSPORTATION FOR MY CHILD. IN THE EVENT I CANNOT BE REACHED IN AN EMERGENCY, I HEREBY GIVE PERMISSION TO THE PHYSICIAN SELECTED BY THE CAMP DIRECTOR TO SECURE AND ADMINISTER TREATMENT, INCLUDING HOSPITALIZATION, FOR THE PERSON NAMED ABOVE. THE COMPLETED FORM MAY BE PHOTOCOPIED FOR TRIPS OUT OF CAMP.

Signature of parent/guardian _____ **Date** _____