



Register

Ages 12 - 18
June 16 - 20

Cost \$220 + \$20 Security Deposit

**Speakers - Steve Allison,
Alexis Rea, & Austin Rohm**

2TIMOTHY 3:16

**ALL SCRIPTURE IS INSPIRED BY GOD
AND IS USEFUL TO TEACH US WHAT
IS TRUE AND TO MAKE US REALIZE
WHAT IS WRONG IN OUR LIVES. IT CORRECTS
US WHEN WE ARE WRONG AND TEACHES US TO DO WHAT IS RIGHT.**

r e v o l u t i o n ' 2 5

Camper Name: _____

Indiana South District Revolution Registration & Information

REMINDER: Camp is only for those who have completed 6th grade through 2024 graduates

NAME: _____ AGE: _____ M/F: _____

ADDRESS: _____

CITY: _____ ZIP: _____ PHONE: _____

GRADE LAST COMPLETED: _____ DATE OF BIRTH: _____
(include birth year)

SHIRT SIZE: _____ ROOMMATE PREFERENCE: _____
(no guarantees)

CHURCH NAME: _____

PARENT/GUARDIAN NAME: _____

EMERGENCY PHONE NUMBER: _____

PARENT/GUARDIAN SIGNATURE

CAMPER SIGNATURE

*By signing this form, the camper agrees to follow all camp guidelines, and both parent and camper understand that the camper will be sent home for serious violations of camp rules (no smoking/tobacco/drugs/alcohol or inappropriate behavior with any other campers, leaving the campgrounds without permission, etc). Students should also refrain from wearing immodest clothing or clothing with inappropriate pictures or wording. **NO CELL PHONES, MEDIA DEVICES, OR LIKE ITEMS.** There will be a charge made for damage to rooms or campgrounds.*

Camper Name: _____

Health and Medical Records

GENERAL INFORMATION

Name _____ Date of Birth _____ Age _____

Address _____

City _____ State _____ Zip _____ Phone (____) _____

Church _____ Youth Pastor/Leader _____

Health Insurance Company _____ Policy No. _____

In case of an emergency, notify:

Name _____ Relationship _____

Home Phone (____) _____ Mobile Phone (____) _____

Name _____ Relationship _____

Home Phone (____) _____ Mobile Phone (____) _____

HEALTH HISTORY

Yes	No	CONDITION	EXPLANATION
		Asthma; Last Attack (MM/YY) __/ __	
		Diabetes Type 1 ___ or Type 2 ___	
		Hypertension	
		Ear/Sinus problems	
		Psychological/Emotional problems/Behavioral problems	
		Seizures: Last Seizure (MM/YY) __/ __	
		Past Surgical Procedures (please include dates)	
		Other:	

Is your child allergic to or does your child have an adverse reaction to any of the following?

YES	NO	ALLERGIES or REACTION to	EXPLANATION (Reaction, usual treatment)
		Medication	
		Food, Plants, Insect Bites	

Camper Name: _____

MEDICATIONS

List ALL medications currently used. If additional space is needed, please photocopy this part of the health form. Inhalers and EpiPen information MUST be included, even if they are for occasional or emergency use only.

__ No Medications __ See Attached Medication Sheets

Medication _____ Strength _____ Frequency _____ Reason _____	Medication _____ Strength _____ Frequency _____ Reason _____	Medication _____ Strength _____ Frequency _____ Reason _____
Medication _____ Strength _____ Frequency _____ Reason _____	Medication _____ Strength _____ Frequency _____ Reason _____	Medication _____ Strength _____ Frequency _____ Reason _____

Please bring enough medication in sufficient quantities and in the ORIGINAL containers. Any medication not in original containers will NOT be administered. Please include inhalers and EpiPens.