

# KIDS KAMP 2026

JESUS RAVE | MAKING ALL THINGS NEW

# LEADER REGISTRATION FORM

Jr. Leaders MUST be 14 or older and have their pastor's recommendation AND be approved by the Kamp Director, Crystal Beland.

## AUTHORIZATION TO PARTICIPATE

*(Under 19 MUST have signature of Parent or Guardian)*

This permission is given by me with the knowledge of the conditions and activities planned during the event. I know of no physical or mental disability which would impair my participation except as noted below or on the reverse side of this form.

## MEDICAL CARE AUTHORIZATION

I understand that in the event of illness or injury, every reasonable effort will be made to provide proper and prompt medical attention and to receive verbal authorization from me before medication is prescribed or medical procedures are begun; however, I do hereby authorize the kamp nurse, physician, and/or hospital to undertake such treatment of and perform such services (including surgical services) for the individual named above as are reasonably indicated by the circumstances without such authorization. Telephone numbers where my emergency contact may be reached:

Emergency Contact Name:

Phone Numbers:

Signature for authorization

*(Under 19 MUST have signature of Parent or Guardian)*

Date of authorization

**Kamp Date: July 27-31, 2026**  
**Registration Deadline: July 1, 2026**

Circle a T-shirt Size:

Adult Sizes: S M L XL XXL

Church Attending with: \_\_\_\_\_

If the person is over 18, I can verify they have a background check on file. Yes No

I recommend this person as a  Leader  Jr. Leader:

\_\_\_\_\_  
Signature of Senior Church Staff Member

## LEADER INFORMATION\*

\*This form is to be completed by the Jr. Leader's parent or legal guardian and MUST be returned before the individual may attend Kids Kamp.

Name: \_\_\_\_\_

Preferred Name for nametags:

*(Pastor, Mr., Mrs., Ms.)* \_\_\_\_\_

Phone Number: \_\_\_\_\_

Gender: Male Female Date of Birth: \_\_/\_\_/\_\_\_\_ Age: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

Which age group do you work best with? 3rd 4th 5th 6th

Jr. Leaders ... What excites you the most about kamp?

**All Leaders MUST complete and attach the Medical Information Form**

Return \$25 Fee & Completed Forms to Your Church Appointed Camp Coordinator  
Make Checks Payable to Your Church.

If you are under 19, this form requires a parent or guardian to sign (lower left of the form)

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# MEDICAL INFORMATION FORM

**If the Leader/Jr. Leader is NOT covered by insurance, please sign the following statement:**

I hereby state that I have no health insurance in force at the present time that covers the above named leader.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

## HEALTH INSURANCE COVERAGE

Our camp has an insurance program to pay for the medical expenses of injuries that result from an accident that occurs while anyone is involved in an event sponsored by us. Our policy DOES NOT cover illness. Furthermore, our insurance is SUPPLEMENTAL to the insurance you carry yourself. Our policy will pay whatever your insurance does not pay (including deductibles) of any covered expense up the limit of our policy. If you do not have medical insurance, our policy will pay for all covered expenses up to the limit of our policy. If medical care is needed, expenses will be billed to you and/or your insurance company. You may attach a copy of your medical card, but it is not required.

Policy Holder's Name: \_\_\_\_\_

Relationship to Attendee (if other than self): \_\_\_\_\_

Health Insurance Company: \_\_\_\_\_

Policy Number: \_\_\_\_\_

Address of Insured (if different than attendee):  
\_\_\_\_\_

Address of Insurance Company: \_\_\_\_\_

### EMERGENCY CONTACT INFO

Emergency Contact #1:

Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Emergency Contact #2:

Name: \_\_\_\_\_

Phone: \_\_\_\_\_

## ATTENDEE'S INFORMATION

This form is to be completed by the participant's parent/guardian if under 19 or by your self if you are a leader. This form MUST be returned before the individual may attend camp as a LEADER.

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Age: \_\_\_\_\_ Weight: \_\_\_\_\_ (only required if under 19 years of age)

## CHRONIC MEDICAL ISSUES

Please place a check next to any chronic issues the leader has and include any specific information that the Kamp Staff needs to know

None

Bleeding Disorders

Behavioral

Asthma

Heart Defect/Disease

Ear Infections

Bed-Wetting

Diabetes

Other (specify):

## ALLERGIES

Please place a check next to any allergies the leader has and include any specific information the Kamp Staff needs to know

None

Food

Insect Bites

Medicine/Drugs

Plants/Pollen

Animals

Other (specify):

**LIST ALL MEDICATIONS, DOSES, & TIMES ON BACK**

# DAILY MEDICATION LOG

## MEDICATION INFORMATION

Any medications sent to camp need to have detailed instructions printed on the bottle/package. If your child has multiple medications, please put them all in a large zip-loc bag labeled with your child's name & a phone number where you can most easily be reached. We have an excellent nurse who dispenses all of our medications, but we need legible and complete instructions. Thank You!

Do not forget to list (and send along) frequently used Over-the-Counter medications for allergies, pain, stomach ache, etc...

Attendee's Name: \_\_\_\_\_ Team Color: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Kamp Counselor: \_\_\_\_\_

Address: \_\_\_\_\_ EC Name: \_\_\_\_\_

Allergies: \_\_\_\_\_ EC Phone: \_\_\_\_\_

Medication	Monday	Tuesday	Wednesday	Thursday	Friday

## OTC MEDICATIONS

By checking the boxes I, the parent or guardian of the attendee, grant permission for the nurse to administer these OTC medications

- Acetaminophen       Benadryl       Ibuprofen  
 TUMS       Throat Lozenges       Claritin

- I, THE PARENT OR GUARDIAN OF THE ATTENDEE, DO NOT AUTHORIZE THE ADMINISTRATION OF THESE OTC MEDICATIONS WHILE AT KAMP

\_\_\_\_\_  
Parent's Signature

\_\_\_\_\_  
Date