

ADULT REGISTRATION/MEDICAL FORM

Susquehanna Conference of the UM Church, Camp & Retreat Ministry

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Name _____ Male _____ Female _____
Address _____ DOB _____
City _____ State _____ Zip _____
Email Address _____
Home Phone () _____ Cell Phone () _____
Bunkmate _____
Camp Choice: Date _____ Site _____
Description _____
Church Name _____ District _____
Church City _____
Emergency contact person _____
Relationship to camper _____
Home Phone () _____ Cell Phone () _____
Health Insurance Co. _____
ID/Policy No. _____ Group No. _____
Dietary needs/food allergies _____
Health issues we should know: Diabetes _____ Heart Disease _____ Asthma _____
High Blood Pressure _____ Others _____
Individual Payment \$ _____ Church Payment \$ _____

PLEASE READ CAREFULLY – I do give permission for my name, address, phone number, and email address to be shared with other persons in this retreat experience. **I do** give permission for still or video pictures of me to be placed on the Susquehanna Conference website and Social Media pages in a camping context.

(Signature)

(Date)

FOR OFFICE USE ONLY: Date Received _____	Date Processed _____
Camp # _____	Fee \$ _____
Family Check # _____	Amount \$ _____
Church Check # _____	Amount \$ _____
Other Check # _____	Amount \$ _____
Campership _____	Confirmed _____

THIS FORM MAY BE PHOTOCOPIED