



No Part of the Registration Process May Be Accomplished by Telephone or Fax.  
 The CPA Office Must Have An Original, Signed, Notarized Registration Form.  
 PLEASE COMPLETE ALL SECTIONS - INCOMPLETE FORMS WILL BE RETURNED WITHOUT REGISTERING

EVENT: 2011 CHI RHO MID-WINTER RALLY Participant's Name: \_\_\_\_\_

**EMERGENCY CONTACT INFORMATION**

Father/Guardian: \_\_\_\_\_ Hm Phone: \_\_\_\_\_

Wk Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Mother/Guardian: \_\_\_\_\_ Hm Phone: \_\_\_\_\_

Wk Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

**MEDICAL INFORMATION** – (See Page 1 for Notarized Medical Release Signature)

Insured's Name: \_\_\_\_\_

Medical Ins. Co. \_\_\_\_\_ Policy # / Grp # \_\_\_\_\_

Drug Ins. Co. \_\_\_\_\_ Policy # / Grp # \_\_\_\_\_

A physical exam is not required, but highly recommended. This is especially true if you have questions concerning your child's health and activities at this event. Please complete all medical questions asked on this form. Participants will be covered by insurance for each event.

Prescription Medications: RX Name / Amount / Frequency		

Over-the-Counter Medications: Name / Amount / Frequency		

*Please make sure that a participant who must receive medication during camp brings a sufficient quantity of the medication with him/her and that the medication arrives in the original container with dosage and storage instructions. Participants who take medication for psychological or attention disorders need their medication for a good camping experience. Please send such medication with the camper unless otherwise directed by a health care professional.*

**Recent Hospitalization (Reason)**

Allergies	Type of Reaction

Date of Last Tetanus Shot	Dietary Restrictions

**Physical Limitations/Restrictions**

**Are there any conditions, concerns, or information of which we should be aware?**

**CHECK THE CONDITIONS WHICH THE PARTICIPANT HAS HAD OR IS NOW SUBJECT TO:**  
*Please provide additional information for any checked items. Attach additional pages as needed.*

<input type="checkbox"/> ADHD	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heat Stress
<input type="checkbox"/> Appendicitis	<input type="checkbox"/> Fainting	<input type="checkbox"/> Recent Illness
<input type="checkbox"/> Asthma	<input type="checkbox"/> Hernia	<input type="checkbox"/> Recent Exposure to Contagious Disease
<input type="checkbox"/> Bed wetting	<input type="checkbox"/> Hyperactivity	<input type="checkbox"/> Sleepwalking
<input type="checkbox"/> Convulsions	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Other:
<input type="checkbox"/> Chronic Infection	<input type="checkbox"/> Heart Problems	

*Please type or print; complete all blanks on both sides of form; obtain all specified signatures; and have form notarized.  
 Make checks and other forms payable to your church and return to them. The church will send completed forms with fee payment to:*

Coastal Plains Area-CCSW  
 11750 Memorial Drive; Houston, TX 77024