



REGISTRATION FORM

IDENTIFICATION

Camper's Name _____

Street Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Email _____

Male _____ Female _____ Date of Birth _____

Grade going into this fall _____

Church _____

Address _____

Pastor _____

Father's Name _____

Street Address _____

City _____ State _____ Zip _____

Mother's Name _____

Street Address _____

City _____ State _____ Zip _____

Mail to:

Baron Greene
3300 Ridge Road
Bloomsburg, PA 17815

Email to:

campcalvaryofbloom@gmail.com
and attach as a pdf or
word document

Questions?

Call Baron Greene @
570.784.4172.
Send an email to
campcalvaryofbloom@gmail.com





REGISTRATION FORM

MEDICAL INFORMATION

Camper's physician _____ Phone _____

Date of Birth _____ Date of last tetanus shot _____

Allergies _____

Type of allergic reaction _____

Treatment for allergic reaction _____

Pre-existing medical condition _____

Medications _____

Specific restrictions _____

Reason for restrictions _____

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PARENTAL CONSENT

I understand that in the case of a medical emergency, every effort will be made to contact me (the legal guardian of the youth). If contact is not possible, I hereby give my permission to the physician selected by the tournament staff to hospitalize and properly treat my child (as named above). I also affirm that the medical information on this form is correct and complete to the best of my knowledge.

Parent or Guardian Signature: _____

Date: _____

