NLR Horsin' Around
Registration Form

Please mark the session you will be attending and fill in all the information below and on the next page. Each session costs $125. If you have any questions please feel free to call 918.422.5506 or email info@newliferanch.com. Horsin Around is for campers grades 3-12.

☐ March 26-28, 2010
☐ October 29-31, 2010

Name:
Birthday: / /
Age:
☐ Male
☐ Female

Address:

City:
State:
Zip:

Home Phone:
email:

Emergency Contact One:

Relationship :
Phone:

Emergency Contact Two:

Relationship :
Phone:

☐ I attended NLR in 2009
☐ I have completed horsemanship ranks at NLR
☐ I own a horse
☐ I ride often
Rank Completed:

What do you hope to gain from this weekend?

☐ I am paying with a check. It is enclosed.
☐ I am paying with a credit card.

Card Number:
Expiration:
CCV Code:
☐ Visa
☐ Master Card

Please mail this form to:
160 New Life Ranch Dr.
Colcord, OK 74338

or fax it to:
918.422.5644

Health Form

(Please notify NLR in writing if any of the information on this form changes before camp.)

Camper Name: ____ Week: ___________

HEALTH HISTORY
(Check, if applies. Give approximate dates.)

_____Frequent Ear Infections
_____Heart Defect/Disease
_____Convulsions/Epilepsy
_____Diabetes
_____Bleeding/Clotting Disorders
_____Hypertension
_____A.D.D./A.D.H.D
_____Mononucleosis
_____Bedwetting
_____Sleepwalking

_____Mononucleosis
_____Bedwetting
_____Sleepwalking
_____ Chicken Pox
_____ Measles
_____ German Measles
_____ Mumps

Food Allergies: _________________________
____
____

ALLERGIES (Dates not needed)
_____Hay Fever
_____Ivy Poisoning, etc. (see below)
_____Insect Stings (see below)
_____Asthma
_____Penicillin
_____Other Drugs
List:______________________________

Is allergy severe enough to keep your child from participating from activities in the woods?
Yes _____ No _____

Family physician: ____________________ Phone: (_____)_________ Dentist/Orthodontist: __________________ Phone: (_____)_________

Disabilities, recurring illnesses, psychological conditions we should be aware of *(give dates):* ____________________________________
____

Activities limited by a physician: ____

Any dietary restrictions? ____

(NLR will not provide special meals, but we will inform our staff of a camper's restrictions and help them choose allowed foods from our regular menu.)

List any medication to be administered at camp & diagnosis or reason for taking *(specific times & doses):* ___________________________

****NO MEDICATION WILL BE GIVEN WITHOUT SPECIFIC ADMINISTRATION INSTRUCTIONS**** ***(All medication must be turned into the nurse upon arrival at camp. Campers will not be allowed to have medication in their cabin.)***

FOR FEMALES (next two lines):
Has she menstruated? __________ If not, has she been told about it? __________ If so, is her menstrual history normal? _______
Special Instructions? ____

Immunizations current? *(circle one)* Yes No Date of last tetanus booster: ____ /____ /____ Date of last physical exam ____ /____ /____

CAMPER PROFILE – please fill out the information below to help our counselors.

Has the camper been affected by a death, divorce or traumatic experience recently (or is still dealing with one of these situations)? If so, please explain: ____

What three words describe your camper's personality? ____

Is your child a Christian? If so, what role does Christ play in his/her life, if any? ___________________________

Special concerns or needs that you have as a parent regarding your camper while he/she is at camp? __________________

What do *you* desire your camper to gain from camp? ____

What does *your camper* want to gain from camp? ____

INSURANCE INFORMATION: ***Note here if you don't have insurance:*** ☐ ***Health Insurance Carrier:*** ______________________

Insurance Mailing Address: *(Street, City, State, Zip)* ____

Group #: ____________________ Policy #: ______________________ Co-Pay Amt: $_________ Deductible Amt: $__________

Primary Policy Holder Name: _______________ Policy Holder ID (SSN): _______________ Policy Holder Date of Birth: ___ /___ /___

Policy Holder Employer: _________________ Camper Insurance ID (SSN):_________________ Camper Date of Birth: ___ / ___ / ___

PLEASE READ CAREFULLY: I hereby attest that I have read and reviewed this form and have completed it accurately and will report any information that may change. I therefore agree that this child may participate in all camp activities including travel off of the property. Also, I give permission for NLR to use images and recordings of my child/ward without further compensation. I realize that in the event of an illness or injury while at camp or while participating in it's activities, medical treatment may be required. I give permission for the medical personnel selected by the camp director to order any medical procedures, including x-rays, routine tests, treatment, hospitalization and transportation. Furthermore, I agree to bear the cost of all such treatment. I also agree to hold harmless New Life Ranch, it's staff, and board of directors from any and all liabilities, claims, demands and causes of action whatsoever which may arise due to the participation of myself or this child in said activities.

And for our camp Doctor, Community Physicians Group:
I hereby authorize payment directly to Community Physicians Group and any consulting physicians insurance benefits otherwise payable to me or my minor dependents. I understand that I am financially responsible for charges not covered by this authorization. I hereby authorize release of information requested of Community Physicians Group and any consulting physician. I further agree to allow Community Physicians Group to release medical information on me or any of my minor dependents if requested by any insurance company for purpose of determining benefits payable.

Parent/Guardian Signature: ____ **Date**: ______________