

**Adventure Experiences, Inc.**

#2 Illinois Almont, CO 81210

(970) 641-4708

**CAMP REGISTRATION FORM**

**PLEASE COMPLETE** (print clearly or type)

Group name: \_\_\_\_\_ Trip Dates: \_\_\_\_\_

Participant: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Ht: \_\_\_\_\_

Address: \_\_\_\_\_ Gender: \_\_\_\_\_ Wt: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone #: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Fax/email: \_\_\_\_\_

**Authorized to take camper from camp:**

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

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

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

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

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

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

**In Case of Emergency Notify:**

Parent/Guardian/Spouse: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work: \_\_\_\_\_

Home Address: \_\_\_\_\_

Work Address: \_\_\_\_\_

If not available, notify: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work: \_\_\_\_\_

Home Address: \_\_\_\_\_

**Health Care Information:**

Name of Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

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

Date of last physical examination \_\_\_\_\_ (within the last 24 months for those under age 18)

Do you carry family medical/hospital insurance? YES NO

Carrier: \_\_\_\_\_ Policy or Group # \_\_\_\_\_

Do you have any special food needs? (ie: vegetarian) \_\_\_\_\_

Please describe: \_\_\_\_\_