



## Mount Pleasant Baptist Church

2516 Squirrel Hill Road ▪ Herndon, VA 20171

Phone: (703) 793-1196 ▪ Fax: (703) 793-1197

[www.mtpleasantbaptist.org](http://www.mtpleasantbaptist.org)

Pastor: Rev. Dr. James L. Graham, Jr.

### Christian Camp

### The C.R.O.S.S.

### APPLICATION FOR ENROLLMENT

Child's Name: \_\_\_\_\_  
*Last First Middle*

Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_ Grade this Fall: \_\_\_\_\_

Child's Social Security Number: \_\_\_\_\_ T-Shirt Size: S M L XL

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

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

Does your child have any special academic needs?  Yes  No If yes, please explain. \_\_\_\_\_

(Registration)

Payment Schedule:  Session-1 Due: March 16  Session-2 Due: April 20

Registration Fee: \$25.00 per session (Non – refundable)

Date Received: \_\_\_\_\_ Check #: \_\_\_\_\_

---

Payment Schedule:	<input type="checkbox"/> Session-1 Due: April 6 June 29 thru July 24 6:30 a.m. to 6:00 p.m. (M-F) \$575.00	<input type="checkbox"/> Session-2 Due: May 8 July 27 thru August 21 6:30 a.m. to 6:00 p.m. (M-F) \$575.00
-------------------	---	---

Date Received: \_\_\_\_\_ Date Received: \_\_\_\_\_

Check #: \_\_\_\_\_ Check #: \_\_\_\_\_

\*\*\*Please make checks payable to: Mt. Pleasant Baptist Church\*\*\*

(Note Area: Christian Camp/Child's Name)

**Family Information (Confidential)**

Father's Name: \_\_\_\_\_  
*First Middle Last*

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Pager#: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

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

Mother's Name: \_\_\_\_\_  
*First Middle Last*

Pager#: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

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

Marital Status of Parents:  Married  Separated  Divorced  Other \_\_\_\_\_

**Persons Authorized to pick up child/children:**

1. \_\_\_\_\_  
*Name Relationship Phone#*

2. \_\_\_\_\_  
*Name Relationship Phone#*

3. \_\_\_\_\_  
*Name Relationship Phone#*

**In signing the application form; parents enroll their children with the understanding that the administration may request the withdrawal of any child/children at any time, if in the administration's opinion that the child, and /or parents,/guardian does not uphold a spirit of willing compliance with the overall MPBCCC philosophy.**

**"I have read and agree to cooperate with the standards and policies of Mount Pleasant Baptist Church Christian Camp."**

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

*(Parents must sign for application to be processed. A non-refundable fee must accompany this application.)*

<b>MT. PLEASANT BAPTIST CHURCH'S CHRISTIAN SUMMER CAMP</b> <b>MEDICAL/EMERGENCY INFORMATION:</b>
---

**In the event of an emergency, Mt. Pleasant Christian Camp will attempt to contact a child's parent/guardian. However, in the event that we are unable to reach you, we will contact one of the alternate emergency contacts on your list.**

**1. Please list names and phone number of parents/guardians.**

Mother's Name	Home Phone	Business Phone	Cell/Pager
---------------	------------	----------------	------------

Father's Name	Home Phone	Business Phone	Cell/Pager
---------------	------------	----------------	------------

Guardian's Name	Home Phone	Business Phone	Cell/Pager
-----------------	------------	----------------	------------

**2. In case of accident or illness, I request that MPBCCC contact me. If MPBCCC is unable to reach me, the following persons will be responsible for my child's transportation and care.**

Name	Relationship	Home phone	Business phone
------	--------------	------------	----------------

Name	Relationship	Home phone	Business phone
------	--------------	------------	----------------

**3. In case of an emergency requiring immediate medical attention, your child will be taken to the nearest hospital emergency room. Your signature authorizes MPBCCC to obtain medical care deemed necessary for your child in the event that you cannot be located immediately.**

<i>Physician's Name</i>	<i>Physician's Phone</i>	<i>Health Insurance Provider</i>
-------------------------	--------------------------	----------------------------------

<i>Phone Number</i>	<i>Policy Holder's Name</i>	<i>Policy Number</i>
---------------------	-----------------------------	----------------------

**4. Does your child have a history of:**

- Fainting with exercise?  Yes  No \_\_\_\_\_
- Losing consciousness after an injury?  Yes  No \_\_\_\_\_
- Seizures?  Yes  No \_\_\_\_\_
- Diabetes?  Yes  No \_\_\_\_\_
- Heart problems (chest pain, murmur etc.)?  Yes  No \_\_\_\_\_
- Allergies (food, medicine, pollen etc.)?  Yes  No \_\_\_\_\_
- Does your child carry an inhaler?  Yes  No \_\_\_\_\_
- Does your child have ear problems?  Yes  No \_\_\_\_\_
- Does your child wear glasses?  Yes  No \_\_\_\_\_
- Had any previous surgery?  Yes  No \_\_\_\_\_

**5. Does your child take any medications regularly?**  Yes  No

- 1) Medication: \_\_\_\_\_  
Dosage: \_\_\_\_\_
- 2) Medication: \_\_\_\_\_  
Dosage: \_\_\_\_\_

**I/we authorize and consent to any life saving treatment, and hospital care that, in the best judgment of a licensed physician or dentist is deemed advisable. I/we agree to assume the financial responsibility for all expenses incurred as a result of those services being provided. I/we also agree to be financially responsible for emergency medical transportation.**

\_\_\_\_\_  
**Parent/Guardian Signature**

\_\_\_\_\_  
**Date**