STAFF REGISTRATION

First Name ________________________________

Last Name __________________________________

Address

Street ____________________________________

City ______________________________________

State ___________________ Zip _______________

Home Phone ______________________________

Cell Phone ________________________________

Email _____________________________________

Gender M/F **Date of Birth** _____/_____/_______

If under 18, please fill in the following info:

Father's Name ____________________________

Home Phone ______________________________

Cell Phone ______________________________

Email ___________________________________

Mother's Name ___________________________

Home Phone ______________________________

Cell Phone ______________________________

Email ___________________________________

☐I have read and fully understand all aspects of the Riverside Bible Conference Staff manual and am willing to take suggestions and instructions from the camp leadership and will follow the established rules and policies of the camp.

STAFF HEALTH INFORMATION

Health History:

Asthma Y N Sleepwalking Y N

Medical Conditions: _________________________

____

Do you take daily medications? Y N

Allergic to:

Insect Stings Y N Penicillin Y N

Other Drugs: ________________________________

Foods: _____________________________________

____

Any Dietary Needs/Restrictions? ______________

____

Are immunizations up to date? Y N

Date of last Tetanus Booster: _____/_____/______

Insurance Information:

Company___________________________________

Policy # ___________________________________

Emergency Contact Person (other than parent):

Name ______________________________________

Home Phone ________________________________

Cell Phone __________________________________

Relationship: ________________________________

Liability: In case of emergency, I understand that every effort will be made to contact a parent (if under 18) and the emergency contact person listed. I hereby give permission to the physician selected by the Camp Director to hospitalize, secure proper treatment for, and to order injection, anesthesia, or surgery for myself/my child as named on this card.

Date _____/_____/_______

Signature ___________________________________

Parent/Guardian (if under 18)

____

STAFF OPTIONAL PAYMENTS

CAMP ____________________

( ) Staff t-shirts are provided for your week of service; however, if you would like to purchase a STAFF t-shirt to take home with you, please include a payment of $5.00.	$ ________
( ) Additional funds for the Camp Store/Snack Shop enclosed:	$ ________

CAMP ____________________

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RIVERSIDE BIBLE CAMP

6355 County Road DD Amherst, WI 54406

STAFF

HEALTH CHECK-IN

CHECKED BY: _____ DATE: _____

EXAMINATION:

TEMP _____
LUNGS _____
THROAT _____
EYES _____
EARS _____

Comments:

_____
_____

Health History Notes:

_____
_____

Medical Condition Notes:

_____
_____

CHECKED BY: _____ DATE: _____

EXAMINATION:

TEMP _____
LUNGS _____
THROAT _____
EYES _____
EARS _____

Comments:

_____
_____

Health History Notes:

_____
_____

Medical Condition Notes:

_____
_____

STAFF

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CHECKED BY: _____ DATE: _____

EXAMINATION:

TEMP _____
LUNGS _____
THROAT _____
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EARS _____

Comments:

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EXAMINATION:

TEMP _____
LUNGS _____
THROAT _____
EYES _____
EARS _____

Comments:

_____
_____

Health History Notes:

_____
_____

Medical Condition Notes:

_____
_____

STAFF

MEDICATIONS

Date: _____

MEDICATION	FREQUENCY
_____	_____
_____	_____
_____	_____

Date: _____

MEDICATION	FREQUENCY
_____	_____
_____	_____
_____	_____

Date: _____

MEDICATION	FREQUENCY
_____	_____
_____	_____
_____	_____

Date: _____

MEDICATION	FREQUENCY
_____	_____
_____	_____
_____	_____