COVID STATEMENT: Covid-19 is highly contagious and is known to spread mainly from person-to-person contact. By attending Camp Maranatha you agree to abide by the procedures established by the Camp to protect attendees and staff, and you voluntarily assume the risk that you, your child and or your family may be exposed to or infected by Covid-19 either at Camp or when you or your child returns home. You agree to assume all the risks of attendance and participation for you, your child and family, and waive any liability against the Camp, its Director's and Staff, the Appalachian Conference IPHC and any other parties.

Signature:						Date:				
Last Name:			First Name:			CHIAN CONAR				
Address:						OTHE SE				
City: State:			Zip Code:		MINISTRIES   IPHC					
DOB:	AGE:	Email:		-		EST. 1965				
Home Phone #:			Cell #:							
Church:			Pastor:	Pastor:						
Parent/Guardian:			Person Authorized to Pick up Camper							
If riding the church van please designate - CHURCH										
ALL PERSON	IS PICKING	UP CAMPI	ERS WILL BE REQU	JIRED TO SHOW	A PHO	TO I.D., NO EXCEPTIONS.				
		CAMP FE	E: MUST BE PAID	IN FULL BY Augu	st 1, 20	021				
	Girls' Ministries Conference									
REGISTRA	TION			August 6	-					
\$70				Let your heart fully embrace what  I have to say.  Proverbs 4:4						
ALL PA	ARTICIPANTS	REGISTERI	NG DAY OF CAMP	WILL PAY FULL FEE	WITH N	NO T-SHIRT GUARANTEED.				
PLEA		HERE IF FE	EES ARE TO BE JRCH:							
REGISTRATION FEE MUST ACCOMPANY APPLICATION. YOU ARE NOT REGISTERED UNTIL WE RECEIVE THE PROPER DEPOSIT OR FULL REGISTRATION FEE. AFTER AUGUST 1st A REFUND, MINUS DEPOSIT, WILL BE GIVEN.										
			ATTACH A							
Mail to: C	AMP MA	RANATH	A, 5847 OAK G	ROVE AVENUE	, DUB	LIN, VIRGINIA 24084				
ROOM REQUEST:	: (Not Guarar	iteed)	PLEASE CHECK S	SHIRT SIZE: [SIZE NO	OT GUA	RANTEED]				
		ĺ	ADULT: XXXI	L XXL XL	L [	M S CHILD: L M S				
DUE TO CURRENT COVID GUIDELINES, IN THE INTEREST OF OUR CAMPERS AND STAFF, CAMP MARANATHA WILL OBSERVE A CLOSED CAMPUS. THIS WILL INCLUDE ALL SERVICES. PARENTS IF THERE IS AN EMERGENCY SITUATION AND YOU NEED TO VISIT YOUR CHILD, PLEASE NOTIFY THE CAMP OFFICE AT 540-674-5885 OR THE CAMP DIRECTOR AT 276-233-4742. ONCE YOU ARRIVE, CALL THE CAMP OFFICE AND STAY IN YOUR CAR UNTIL SOMEONE COMES TO GET YOU. PLEASE DO NOT COME TO THE DORM.										
			CAMPER CH	HECK-OUT						
Signature:						Date:				
Please Print Name:				-	-	Time:				
Worker's Signature:		-			-	I. D. Verified:				
NOTES:										

In my absence I, hereby authorize the Director of Camp Marnantha or his/her appointee to obtain medical freatment which may be deemed necessary for my child prescription/over the counter drug(s), if any, as listed on this application and/or attachments. (Prescription/Over the Counter drug must be presented in original container with dosage instructions.) I also hereby authorize the proper dispensing of my child's prescription/Over the Counter drugs must be presented in original container with dosage instructions.) I also hereby authorize any physician called upon by the Director of Camp Marnantha, or his/her appointee, to render medical treatment that, in his/her judgment, may be necessary for the well-being of my which it also hereby authorize the Camp Murze to dispense over the counter medication (unless listed) to my child, as he/she deems necessary. By signing this form I declare that I have legal custodial right to do so.  SIGNATURE REQUIRED:  Relationship to Child:  Insurance and/or Government    List Current Prescription or Over-the-Counter Drug(s):    Subscriber   D. or Contract #:	Camp I	Maranatha 2021	MEDICAL INFORMATION and	TREATM	ENT CONSENT FO	ORM					
Camp Maranatha or his/her appointee to obtain medical treatment which may be deemed necessary for my child prescription/over the counter drug(s), if any, as listed on this application and/or attachments. [Prescription/Over the Counter drug(s), if any, as listed on this application and/or attachments. [Prescription/Over the Counter drugs must be presented in original container with dosage instructions.] I also hereby authorize any physician called upon by the Director of Camp Maranatha, or his/her appointee, to render medical treatment that, in his/her judgment, may be necessary for the well-being of my child. I also hereby authorize the Camp Nurse to dispense over-the-counter medication (unless listed) to my child, as he/she deems necessary. By signing this form I declare that I have legal custodial right to do so.  SIGNATURE REQUIRED: Relationship to Child:  Insurance and/or Government Program:  Subscriber I. D. or Contract #:  Insurance Co. Phone #:  Admission Precertification Phone #:  Group Name (Employer):  Group Name (Employer):  Group Name (Employer):  Signature authorization: I authorize the release of any medical information necessary to process a claim for my dependent and this Camp Maranatha Application. I authorize the release of any medical information necessary to process a claim for my dependent and this Camp Maranatha Application. I authorize the release of any medical information necessary to process a claim for my dependent and this Camp Maranatha Application. I authorize the release of any medical information necessary to process a claim for my dependent and this Camp Maranatha Application. I authorize the release of any medical information necessary to process a claim for my dependent on the physician or supplier of service rendered to my dependent. I understand that I will be responsible for any balance due. By signing this form I declare that I have legal custodial authority to do so.  SIGNATURE REQUIRED:  Relationship to Child:  IT IS THE RESPONSIBILITY OF THE PARENT/SURADIAN TO NOTIFY TH	In my absence I.				. hereby auth	orize the Director of					
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Group Name (Employer): Group Number: Employer's Address: Employer's Phone #: List any medical conditions, disabilities/allergie Has, or is, your child being treated for any Mental Health issue or condition?  YES   NO     Insurance Authorization: I authorize the release of any medical information necessary to process a claim for my dependent named in this Camp Maranatha Application. I authorize payment of medical benefits to the physician or supplier of service rendered to my dependent. I understand that I will be responsible for any balance due. By signing this form I declare that I have legal custodial authority to do so.  SIGNATURE REQUIRED: Relationship to Child:  IT IS THE RESPONSIBILITY OF THE PARENT/GUARDIAN TO NOTIFY THE CAMP DIRECTOR IF A CAMPER'S MEDICAL HISTORY CHANGES PRIOR TO THEM COMING TO CAMP! NOTIFY THE CAMP DIRECTOR BY CALLING 540-674-4131 EXT. 201.  IT IS THE PARENT'S RESPONSIBILITY TO CONFIRM RECEIPT OF INFORMATION.  ACTIVITY PERMISSION FORM TO BE SIGNED BY PARENT OR GUARDIAN  The undersigned hereby and forever releases and discharges Camp Maranatha, the Appalachian Conference of the IPHC and its agencies, employees, officers and/or directors, of any and all liability of any nature which may arise while their child,  is a camper, as set forth in this application. The undersigned further covenants and agrees to never sue or file a claim against the aforesaid Camp Maranatha and/or the Appalachian Conference IPHC, its agencies, employees, officers and/or directors for any injury which may occur to said camper while he/she is involved in any of the activities of Camp Maranatha, which may include, but not be limited to, swimming, paintball, go carts, challenge course, climbing tower, zip line, archery, air rifles, inflatable games, etc., either on or off premises. By signing this application Parents/Guardians understand that there are risks associated with these activities including but not limited to loss or damage to personal property, injury or fatality and Camp Maranatha, nor will its staff or											
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IF A CHILD/STAFF IS FOUND TO HAVE LICE OR NITS, THEY WILL BE SENT HOME AND CANNOT RETURN.											
IF A CHILD/STAFF IS FOUND TO HAVE LICE OR NITS, THEY WILL BE SENT HOWE AND CANNOT RETURN.  1/2 TOTAL CAMP FEE WILL BE REIMBURSED.	IF A C										
DEPOSIT: DATE: CK#: REFUND:						FUND:					
OFFICE LISE ONLY:	OFFICE USE ONLY:	PAYMENT:	DATE:	CK#:		Revised 4/202					
DAVMENT: DATE: CV#.		FATIVIENT:	DATE:	UN#:		Revised 4/202					