



Please send signed registration form along with \$20.00 non-refundable deposit to: **Broken Arrow Camp PO Box 469 Pearce Az 85625**

Name _____ Male _____ Female _____ Age _____

Mailing Address _____

City _____ State _____ Zip _____

Home phone () _____

Home Church _____ Phone _____

Emergency phone contact:

Daytime: _____ Nighttime: _____

Health Problems, or handicaps:

(example: epilepsy, bed-wetting, sleepwalking, etc.)

Drug Allergies or other Allergic reaction:

I give permission for my child to attend Broken Arrow Camp and to engage in all camp activities. I understand that Broken Arrow is not liable for any accidents or injuries that may occur while my child is at camp. I also understand that if my child must be sent home because of disciplinary or other problems, I will assume the additional transportation cost. **IN CASE OF MEDICAL EMERGENCY**, I hereby give permission to the physician selected by the Camp Director, to hospitalize, secure proper treatment for, and order injection, x-ray, anesthesia or surgery for my child.

Date _____ Parent/guardian signature _____