

SEND FORM & FEES TO:

Darnall Gun Works
6125 E. 1175 North Road
Bloomington, IL 61704

NRA YOUTH SHOOTING CAMP

"2009" CAMPER REGISTRATION FORM

August 6-9, 2009

Last Name _____ **First** _____ Circle: Male Female

Address _____ **City/State/Zip** _____

Age: _____ **Birthday** __/__/____ **Home Ph. #** _____

Camper Fee: \$95.00 _____ Check # _____ Cash _____

Early Registration By July 15, 2009 Camper Fee: \$85.00 _____

Not including the Camper/Jr. Staff, How many will be attending Sunday's Picnic? _____

Camp Information

T-Shirt (Mark)		Grade Attended 2009-2010			Years Attended Camp		
___ Mens S	___ Mens XL	___ 3rd	___ 7th.	___ 11th	___ 1996	___ 2000	___ 2004
___ Mens M	___ Mens 2XL	___ 4th	___ 8th	___ 12th	___ 1997	___ 2001	___ 2005
___ Mens L	___ Mens 3XL	___ 5th	___ 9th		___ 1998	___ 2002	___ 2006
		___ 6th	___ 10th		___ 1999	___ 2003	___ 2007
							___ 2008

Attention: Provide Campers Social Security # _____ (For Emergency Use)

If Social Security # is not provided parent must sign stating they refuse to provide SS#.

Parent Signature _____ Dated _____

Health History

IN CASE OF EMERGENCY PLEASE CONTACT:

Name _____ Relationship _____

Address _____ City/State/Zip _____

Home Ph# () _____ Work Ph. # () _____ Cell Ph. # () _____

Other Instructions: _____

Family Physician's Name _____ Physician's Ph. # () _____

DOES THE CAMPER HAVE ANY OF THE FOLLOWING? YES _____ NO _____

If yes check those applicable: Asthma___ Fainting Spells___ Convulsions___ Heart Trouble___ Diabetes___

Allergy or reaction to any food, medication, insect toxin, etc? _____ Specify: _____

DOES THE CAMPER HAVE DIFFICULTY WITH ANY OF THE FOLLOWING? YES _____ NO _____

Eyes___ Ears___ Nose Throat___ Lungs___ Digestion___

DOES THE CAMPER HANE ANY CONDITIONS REQUIRING MEDICATION? YES _____ NO _____

If yes, please explain _____

MEDICATION BROUGHT TO CAMP MUST BE LEFT WITH THE MEDICAL PERSON AT CHECK IN.

List below any other medical restrictions you feel staff should be aware of to assist your child participating at camp: _____

PARENTAL AUTHORIZATION: This Health History is Correct To The Best of My Knowledge, and the person described has permission to engage in all prescribed activities except as noted by me and the physician. In the event I cannot be reached in an emergency. I hereby give permission to the physician, selected by the leader in charge, to hospitalize, secure proper anesthesia, or to order injection or surgery for my son/daughter.

Signed: _____ **Date:** _____

BE SURE TO COMPLETE A RELEASE FORM