

Old Paths Baptist Church

Summer Camp 2026 Registration Form

Camper Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Camper Grade for the 26/27 School _____ Camper Age: _____

Year: Gender: Male Female

T-Shirt Size (circle one):

YOUTH: SM MD LG

ADULT: SM MD LG XL 2X 3X

Parent / Guardian Information:

Name: _____

Relationship to Camper: _____

Cell Phone Number: _____

Email Address: _____

Emergency Contact: _____

Emergency Phone Number: _____

Special/Physical Needs and Significant Food Allergies: _____

Old Paths Baptist Church Member (Y/N): _____

If No, name of person who invited Camper: _____

Registration Forms are due by June 21, 2026. Completed and signed forms can be emailed to oldpathsbaptist1611@gmail.com. Cost of camp is \$100 per Camper. Checks can be made payable to Old Paths Baptist Church and can be mailed to 1600 SW Smith St. Blue Springs, MO 64015.

2026 Old Paths Baptist Church Camp Health Form

Camper's Full Name:			Date of Birth:	Height and Weight:
Address:			City:	State/Zip Code:
Emergency Contact:	Relationship:	Work Phone:	Cell Phone:	Home Phone:

Chronic Health Concerns:

Check those that pertain to your camper and describe how it is handled at home.

- Allergies
 Asthma
 Bedwetting
 Seizure Disorder
 Headaches
 Menstrual Cramps
 Sleepwalking
 Frequent Ear Infections
 Surgical History of Consequence
 Diabetes
 Fainting
 Glasses/Contact Lenses
 Hearing
 Other

This camper has no chronic health concerns and is capable of full participation in program.

****If you selected Allergies or Asthma please fill out the allergy/asthma sections of this form. Attach any additional information that is pertinent to your camper's medical condition(s).**

Allergies:

Check those that apply to your camper.

Drug Allergies:

- This camper has no known allergies

 This camper is allergic to the following medication(s): _____
 Causes anaphylaxis? Yes No
 Describe the reaction to this medication and what is done to manage it: _____

Food Allergies:

- This camper has no known allergies

 This camper is allergic to the following (circle all that apply): Peanuts Milk/Dairy Tree nuts
 Gluten Fish Eggs Soy Meat Other: _____

 Causes anaphylaxis : Yes No

Describe the reaction and what is done to manage it: _____

Asthma:

The program takes place in the outdoors. Your camper will be exposed to trees, grasses, dust, pollens, molds, insect bites and a host of other environmental factors. We recommend that campers who use an “as needed” inhaler turn them in so the nurse or counselor can carry the inhaler with them and respond to your child in any emergency situation. **Please label the inhaler with the child’s full name.**

What triggers your child’s asthma? Provide details about the triggers:

- Exercise _____
- Dehydration _____
- Food Items _____
- Allergen _____
- Other _____
- Fatigue _____
- Stress _____
- Smoke _____
- Respiratory infections/common cold _____

At what point should we notify you (Parent/Guardian) about an Asthma Flare:

At what point should this child be taken to a physician or hospital:

Medications:

“Medication” is any substance a person takes to maintain and/or improve their health and includes vitamins or supplements..

- This camper **will not** take any daily medication while attending
- This camper **will** take daily medication(s) . *while attending

***It is important that all medications be turned into the nurse to maintain safety**

*Unless requested otherwise, Morning meds will be passed before/with breakfast
 Afternoon meds will be passed before/with lunch, Night meds will be passed before bed

Please list any medications this Camper will take:

Name of Medication	Dosage	Dosage Time* (Morning, Noon, Night, PRN)	Purpose
1.			
2.			
3.			
4.			
5.			

If nursing assessment suggests benefit of the following camp medications, do we have permission to give: Antacid/Pepto

Ibuprofen Tylenol Benadryl Delsym *weight based dosage tables provided by STL Children’s Hosp

Special Instructions for Medications/Please attach any necessary information regarding the administration of medications for your camper:

Parent/Guardian Printed Name Parent/Guardian Signature Date

**OPBC CAMP 2026
PARENT / GUARDIAN CONSENT FORM**

Child's Name (Last)	First	Middle	
Address	City	State	Zip Code
Name of Facility Three Trails Camp & Retreat Center			
Address	City	State	Zip Code
16200 E US HWY 40	Kansas City	MO	64136
Dates of Attendance July 26th - 30th, 2026			

As the parent or legal guardian of my child, _____, I hereby consent for my child to attend and participate in all activities provided as described above.

Print Name
Signature Date

Additional Information: Exclude from the following types of activities:

You will need to bring your child at 5:00 PM Sunday evening to check them in and pick up will be 9:00 AM Thursday Morning.

***** All Applications/Consent Forms are due Sunday, June 21st *****