Junior Faculty Training Retreat

Friday & Saturday, April 5-6, 2024

Friday Check-In from 6:00-6:30pm Retreat Concludes Saturday at 4:00pm

Registration form & money to be postmarked by Monday, April 1 ($25.00).
LATE Registrations postmarked or hand delivered after Monday, April 1 ($40.00).
*Additional training on April 20 8:30am-12noon for Horse Camps ONLY. No additional charge but Jr. Faculty training MUST be completed too. *

- **You may use this paper form to register or you may register online at www.ljca.org.**
- **If registering by paper, send this form along with the registration fee to:**
  Lake James Christian Assembly 1880 W 275 N Angola, IN 46703
- **All applicants must have their church minister or youth minister complete a recommendation. This is done online via the QR code below or online (just share with your minister or youth minister).**

Recommendation

Name_____ Birth Date_____/_____/_____ Current Grade_____ Sex___

Address_____ City_____ State_____

Zip_____ Home Phone_____ Email Address _____

Church Name_____

Do you plan to help as a Jr. Faculty for Horse Camps? _____No _____Yes

Have you been baptized by immersion? _____ *(Answering "NO" to this question does not at all disqualify you from attending this training retreat. Although we prefer that our Camp Deans enlist faculty who are immersed believers in Jesus Christ, a Camp Dean could choose to use you as a Junior Faculty member based on a variety of positive qualities that would benefit a session of camp.)*

***In Case of Emergency:** I hereby give permission to LJCA to hospitalize, secure treatment, for and to order anesthesia or surgery for my child named above. I understand that every effort will be made to contact me in case of such an emergency, if possible, before any such treatment is administered. I hereby release the Camp from any responsibility other than normal supervision and care. In case of accident I will not hold Lake James Christian Assembly or its staff, management or officers liable unless guilty of negligence. **I understand that camp insurance is secondary!**

Signature of Teenager attending the Retreat_____ Date_____/_____/_____

*Printed Name of Parent or Guardian_____
*Signature of Parent or Guardian_____ Date_____/_____/_____

Emergency contact name _____ Emergency Contact Phone #_____

Year of Last Tetanus Booster:_____ My child is current on all immunizations: ____yes _____no

(Over)

Please list any food, medication, insect or other allergies (you don't need to include seasonal allergies) and describe the reaction and management of the reaction.

Allergies to Foods:_____ Severity of Reaction:_____

Management/Treatment:_____

Other Allergies:_____ Severity of Reaction:_____

Management/Treatment:_____

Medical condition(s) or history and special health/behavioral/physical considerations or limitations. Nothing marked indicates the camper has no medical conditions and is capable of full participation.

Medical

Condition:_____Explained:_____

Recent surgery, injury or permanent conditions that may restrict this camper's activities:_____

Optional: Any recent life changes? (death, divorce, homesickness, etc.):_____

These over-the-counter medications are stocked at LJCA, used to help manage common illness or injury, and dispensed by standing orders signed by LJCA's supervising physician. Some meds are listed as common brand names, though generic may be substituted.

Acetaminophen, aloe vera, ibuprofen, antacid (Tums & Mylanta), antifungal spray, burn gel, Zyrtec, Benadryl (oral & ointment), Epi-Pen (used for anaphylactic reaction), hydrocortisone cream, Lanacaine 1st aid spray, Immodium Ad, Gold Bond medicated power, Midol, pain relief/ointment (Bengay/Biofreeze), Milk of Magnesia, Miralax, Nix, Sudafed, swimmer's ear drops, throat lozenges, tussin, tussin DM, triple antibiotic ointment, bacitracin ointment, Calamine lotion, orajel, sunscreen, docusate sodium (stool softener), Visine AC

Please list medication(s) you DO NOT want your child to have:_____

Current Prescriptions/Non-Prescription Drugs or Medications:_____

Family Physician Name:_____ Physician Phone:_____-_____-_____

Health Insurance Company:_____ ID #_____Group #_____

Insured's Name:_____Insured's Date of Birth_____-_____-_____

Alternate Contact:_____Phone:_____-_____-_____

Relationship of alternate contact person:_____