QHC Youth Fellowship Winter Retreat 2024

February 17th-20th, 2024

Camp Shiloh |http://www.campshiloh.com/| 753 Burnt Meadow Rd, Hewitt, NJ 07421 | 973-728-7845

2024 Camp Shiloh: Contact Information, Medical History, & Release Form

Group Name ___QUEENS HERALD CHURCH_____Retreat Date __2/17-2/20, 2024___
Guest Name _____
Gender _____ Date of Birth _____ Age _____ Height _____ Weight _____
Address _____
City, State, Zip _____
Cell Phone _____ Email _____
Parent/Guard. Name _____ Phone _____
Parent/Guard. Name _____ Phone _____
If Parent/Guardian cannot be reached, please provide alternate emergency contact:
Name _____ Relation _____
Cell Phone _____
Doctor _____ Phone _____
Insurance _____ Policy #_____

- I understand that guests will be traveling to and from camp with group leaders & Shiloh is not responsible for transportation.
- I understand that it is the responsibility of the church/organization guests are going to Shiloh with to supervise at all times.
- I understand that the rules at Camp Shiloh are clearly stated upon arrival and if guests do not follow the rules, parents/guardians may be asked to come pick them up without refund.
- I understand that while at camp, guests may be participating in athletic activities, waterfront activities, & adventure program. The program is run by Shiloh's trained professional staff and proper safety precautions will be taken.
- I understand the risks involved, give permission for above named guest to participate to his/her ability, and release Camp Shiloh of liability.

***I have read and agree to the above statements.**
***Parent/Guardian Signature _____**
***Guest Signature if over 18 _____**

Please identify any medical conditions that might impact above named guest's participation in camp activities, including illness or injury restrictions, limitations, disabilities, special needs. None _____
If Yes, explain: _____
Guest is up to date on all immunizations. _____ Yes _____ No
If No, please explain: _____
If guest will be at Camp Shiloh for longer than 72 hours, please attach immunization records.
Please identify any allergies, describe reaction & management. No Known Allergies _____
Allergy: _____
Reaction: _____
Management: _____
Please identify any medically necessary dietary restrictions or food allergies via Special Diet Request Form: www.campshiloh.com/menu
Please list medications currently used & directions. (Antibiotics, Allergy meds, Inhalers, EpiPen, Insulin, etc.)
Med Name: _____ Dose: _____ Time Taken:_____
Note: All medications should be in original appropriate containers and labeled, kept with group leader, and self-administered.
In the event of an emergency, I understand that every effort will be made to notify necessary emergency contacts.
However, in the event that we cannot contact anyone, I give permission for above named guest's leaders and Camp Shiloh Staff to make necessary decisions regarding their care, including administer first aid at camp, and if necessary arrange for transportation to Chilton Hospital and consent for emergency medical treatment. I agree that I am financially responsible for any fees associated with this medical care.
***Parent/Guardian Signature _____**
***Guest Signature if over 18 _____**
I give permission for any video or still images taken at camp to be used for promotional purposes for Camp Shiloh.
***Parent/Guardian Signature_____**
***Guest Signature if over 18_____**

We accept checks, cash and online payment via Tithely. Please make all checks Payable to QHC and earmark: "Youth Ministry Winter Retreat"
Submission Deadline is January 28th, 2024. *Please submit registration forms/payment to Ariel Wang.*
Questions please ask Jessica Ng at QHC Church Office, 6515 164th, Fresh Meadows, NY 11365