

# Cost, Reservation, and Location

## Cost:

The cost of the week of camp is \$225.00. The cost for adults is the same. Fees include: Lodging for 4 nights, all meals (including the “pizza pig-out” on Monday night), evening concerts, and much more. Cost DOES NOT INCLUDE: Spending money, t-shirts, snacks (like sodas, chips, & candy separate from the meals provided) and other items that can be purchased at the book store.

## Payment:

Payment can be brought and presented the 1st day of camp (Monday).

## Method of Payment:

(Church check preferred) for all attendees

Please make checks payable to: ***Calvary Baptist Church***

## REMEMBER!

**Everyone including adults must have registration form completed and health information form completed.**

## Location:

Williams Baptist College is located 5 1/2 miles North of Walnut Ridge, Arkansas. The turn is off by a huge sign which is displayed by the college. Coming from Walnut Ridge, traveling North on 67 the turn is on the right.

## Mailing Address:

Williams Baptist College  
P.O. Box 3665  
Walnut Ridge, AR 72476

## Phone:

1-800-722-4434  
(After 5pm 1-870-886-9929 or 1-870-886-9827)

# TRIQUEST

2019  
CHURCH  
REGISTRATION  
FORM

Church Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Church Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Contact Person| Youth Pastor/Pastor: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Campers: \_\_\_\_\_ x \$225.00 = Total Enclosed \_\_\_\_\_

Make checks payable to: *Calvary Baptist Church*

## *For Office Use Only*

Date Received: \_\_\_\_\_

# of Attendees: \_\_\_\_\_

Total Amount Received: \$ \_\_\_\_\_

Packet and Receipt Sent: \_\_\_\_\_ Date: \_\_\_\_\_

# TriQuest 2019 | Student Registration

Name: \_\_\_\_\_ Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Cell Phone #: \_\_\_\_\_ Email: \_\_\_\_\_ Home #: \_\_\_\_\_  
Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ 2019-2020 School Grade: \_\_\_\_\_  
Pastor: \_\_\_\_\_ Youth Pastor: \_\_\_\_\_ Church: \_\_\_\_\_  
Name of person to contact in case of emergency: \_\_\_\_\_ Phone: \_\_\_\_\_

## For Office Use Only

Fee \$225.00 \_\_\_\_\_ Room Assignment \_\_\_\_\_ Counselor \_\_\_\_\_

## Health Information

Name: \_\_\_\_\_ Insurance Company: \_\_\_\_\_  
Member Number: \_\_\_\_\_ Family Physician: \_\_\_\_\_  
Physician's Phone Number: \_\_\_\_\_  
Is this camper on any medication? YES \_\_\_\_\_ NO \_\_\_\_\_  
If so, name: \_\_\_\_\_  
Please state past histories (if any) pertaining to (1) allergies (2) diabetes (3) epilepsy  
\_\_\_\_\_  
Has there been a tetanus shot administered in the last 1 yr: \_\_\_\_\_ 2 yrs: \_\_\_\_\_  
Other information stated by parent or legal guardian: \_\_\_\_\_

## Authorization to Consent to Treatment of Minor

I, the undersigned, parent or legal guardian of \_\_\_\_\_,  
(name of attendee)

do authorize \_\_\_\_\_ as agent for the undersigned, to consent to any x-ray, examination, anesthetic,  
(pastor/counselor)  
medical or surgical diagnosis or treatment, and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of any physician and/or surgeon licensed under the provisions of the Medical Practice Act on the medical staff of any accredited hospital, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital.

It is understood that this authorization is given in ADVANCE of any specific diagnosis, treatment or hospital care being required, and is given to provide authority and power on the part of our aforesaid agent to give specific consent to any and all such diagnosis, treatment, or hospital care which the aforementioned physician in the exercise of his/her best judgement may deem advisable.

This authorization shall remain in the effect until \_\_\_\_\_, 2019 unless sooner revoked in writing and delivered to the said agent,

Dated: \_\_\_\_\_, 2019

Parent/Guardian

Relationship

Notary \_\_\_\_\_ Date: \_\_\_\_\_

# TriQuest 2019 Adult Registration Form

Name: \_\_\_\_\_ Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Cell Phone: \_\_\_\_\_ Business Phone: \_\_\_\_\_  
Email: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Gender: Male \_\_\_\_\_ Female \_\_\_\_\_  
Church: \_\_\_\_\_ Pastor: \_\_\_\_\_  
Name of person to contact in case of emergency: \_\_\_\_\_  
Phone Number: \_\_\_\_\_

*For Office Use Only:*

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## Health Information

Name: \_\_\_\_\_ Insurance Company: \_\_\_\_\_  
Member Number: \_\_\_\_\_ Family Physician: \_\_\_\_\_  
Physician's Phone #: \_\_\_\_\_  
Is this camper on any medication? YES \_\_\_\_\_ NO \_\_\_\_\_  
If so, name: \_\_\_\_\_  
Dosage: \_\_\_\_\_  
Please state past histories (if any) pertaining to (1) allergies (2) diabetes (3) epilepsy  
\_\_\_\_\_  
\_\_\_\_\_  
Has there been a tetanus shot administered in the last: 1yr \_\_\_\_\_ 2yr \_\_\_\_\_  
Order information stated by parent or legal guardian \_\_\_\_\_

*Please make copies from this form*