

2026

Brown City Youth Camp Registration Form

Youth Name \_\_\_\_\_

Male / Female Birthdate \_\_\_\_\_ Age \_\_\_\_\_ Grade Completed \_\_\_\_\_

Home Address \_\_\_\_\_

Nights youth staying at camp 7/30 7/31 8/1 8/2 8/3 8/4 8/5 8/6 8/7

Parent/Guardian \_\_\_\_\_ Phone \_\_\_\_\_

Home Address \_\_\_\_\_

Parent/guardian on lot \_\_\_\_\_ Lot # \_\_\_\_\_ Street \_\_\_\_\_

Emergency Contact (other than parent) \_\_\_\_\_ Phone \_\_\_\_\_

ALLERGIES \_\_\_\_\_

Youth Agreement

I have read, understand and agree to abide by all the YOUTH CAMP RULES. I understand that if I don't abide by them I could be dismissed from Brown City Camp and sent home at my own expense. Ignorance of the rules is no excuse for misbehavior.

Youth Signature \_\_\_\_\_ Date \_\_\_\_\_

Release Information

I understand that my youth must check out at the Brown City Youth Office before leaving the campgrounds.

\*\*In addition to myself, my youth MAY BE released from camp to the following persons:

\_\_\_\_\_

\*\*My youth MAY NOT be released from camp to the following persons (include relationship):

\_\_\_\_\_

I have read, understand, and agree that my youth will abide by the Youth Camp Rules. I understand that if he/she doesn't abide by all rules he/she could be dismissed from Brown City Camp and sent home at their own expense. Permission also given for use of images for camp publicity and security.

In case of an emergency, I understand that efforts will be made to contact me; however, if I cannot be reached, I hereby give Brown City Camp and its representatives the permission to act on my behalf in seeking emergency medical treatment for my child in the event that such treatment is deemed necessary or advisable for my child's health, safety and welfare. I give permission to those administering medical treatment to do so, using the measures deemed necessary. I release Brown City Camp, its representatives, and all medical providers from liability in acting in this regard and rendering such medical treatment. I will be fully responsible for all such medical expenses.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

OFFICE USE ONLY

WRISTBAND # \_\_\_\_\_ SMALL GROUP \_\_\_\_\_ DORM \_\_\_\_\_

DORM/MEALS (\$35/night) # of nights \_\_\_\_\_ = \$ \_\_\_\_\_ OR 9 Nights = \$300.00

Amount Paid \$ \_\_\_\_\_ Cash Paypal Check # \_\_\_\_\_ Date \_\_\_\_\_ Staff Initial \_\_\_\_\_

Check In \_\_\_/\_\_\_/\_\_\_ Time \_\_\_\_\_ am/pm Staff Initial \_\_\_\_\_

Check Out \_\_\_/\_\_\_/\_\_\_ Time \_\_\_\_\_ am/pm Staff Initial \_\_\_\_\_

Final Check-Out Parent/Guardian Signature \_\_\_\_\_