

CHAMBERS CAMP

MEDICAL DIETARY FORM

Camper/Staff Information

Name _____ Age _____ Birth Date _____

Please identify specific medical dietary condition or need

Foods or Ingredients that cannot be eaten

Suggested or Recommended Foods

Contact Information

Parent/Guardian Name _____

Home Phone (____) ____ - _____

Cell Phone (____) ____ - _____

Camp(s) Attending (check all that apply)

- | | |
|--|---------------------------------------|
| <input type="checkbox"/> Men's Adventure Weekend | <input type="checkbox"/> Family Camp |
| <input type="checkbox"/> Senior High | <input type="checkbox"/> Junior High |
| <input type="checkbox"/> PT Camp | <input type="checkbox"/> Kaleidoscope |
| <input type="checkbox"/> My Camp | <input type="checkbox"/> Connect |
| <input type="checkbox"/> Discipleship Retreat | <input type="checkbox"/> BYF Retreat |
| <input type="checkbox"/> Ladies Retreat | |

In order for medically necessary dietary needs to be met this form MUST be received at least TWO WEEKS before the camp begins so accommodations can be made.

Click here to submit form via e-mail to chambersdietaryneeds@gmail.com

or print the form and send to be sent to Peter Moon
114 Campground Rd. Beaver Dams, 14812 (315) 436-3068