



**Sis-Q Meadows  
Youth Camp  
July 19 – 26, 2026  
Ages 13-18**

**\$375.00 Registration Fee**

**Register before June 30, 2026  
to receive \$50.00 discount!**

**A Ministry of the West Coast District  
Church of God (7th Day)  
Located at 1000 Airport Rd.  
Cave Junction, OR 97523**

**Camp Directors:**

**Greg & Lorie Haffner  
541-521-8065**

**[lorendahaf@icloud.com](mailto:lorendahaf@icloud.com)**

**AND**

**Harold & Vona Ogren  
541-689-1387**

**[hogren@msn.com](mailto:hogren@msn.com)**

Check-in begins at  
3:00PM July 19, 2026

**DO NOT COME EARLY.**

Facilities are not available until after  
3:00PM.

**CAMPERS MUST BE PICKED  
NO LATER THAN 10:00AM SUNDAY,  
JULY 26, 2026.**

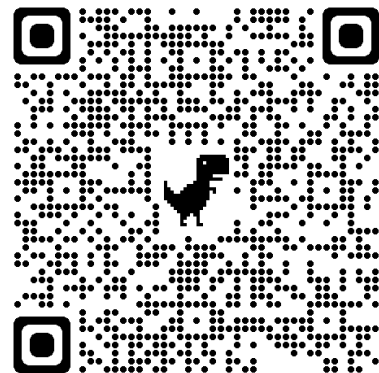
**ITEMS TO BRING**

Bible-Flashlight-Pillow-Jacket-  
Washcloth-Toothbrush-Toothpaste-  
Sleeping Bag-Deodorant-Towels-Soap-  
Sunscreen-Swimsuit (one piece or  
tankini for girls)- Mosquito Repellant

**DO NOT BRING**

Alcohol-Drugs-Tobacco-Vaping  
device-Firearms-Knives-Fireworks

If it is questionable,  
**DO NOT BRING IT!**



**SCAN QR CODE TO REGISTER  
ONLINE or complete paper form**

EMAIL COMPLETED PAPER REGISTRRTION FORM TO [lorendahaf@icloud.com](mailto:lorendahaf@icloud.com)

# SIS-Q MEADOWS YOUTH CAMP July 19 - 26, 2026

**COST \$375.00 - Register by June 30, 2026 to receive \$50.00 off. Pay only \$325.00.** No partial week attenders. Complete form in full legibly. MAKE CHECK PAYABLE TO WEST COAST DISTRICT, mail to Lorie Haffner PO Box 508, Veneta, OR 97487

**Campers Name** \_\_\_\_\_

**Parent/Guardian Name** \_\_\_\_\_

**Street** \_\_\_\_\_ **City** \_\_\_\_\_

**State** \_\_\_\_\_ **Zip Code** \_\_\_\_\_

**Home Phone** (\_\_\_\_\_) \_\_\_\_\_ **Work Phone**(\_\_\_\_\_) \_\_\_\_\_

**Sex** \_\_\_\_\_ **Age** \_\_\_\_\_ **Birthdate: M** \_\_\_\_\_ **D** \_\_\_\_\_ **YEAR** \_\_\_\_\_

**Campers e-mail** \_\_\_\_\_ **(to receive communications after camp)**

**\*Living with (circle one):** Both Parents    Mother    Father    Guardians/Other

**\*Swimming information (circle one):**    **Beginner**    1    2    3    4    5    6    7    8    9    **Advanced**

**\*Baptized:** Yes    No

**\*Home Church** \_\_\_\_\_

**\* Circle T-Shirt Size:** X-Small    Small    Medium    Large    XL    XXL (Adult Sizes)  
*Shirt size will be honored if registration form is received before June 30, 2026*

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**\*I agree to abide by all rules, verbal or written, set forth by the camp staff.**

\_\_\_\_\_  
**Camper Signature**

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**\*By initialing I agree that photos from camp may be used for promotional purposes. Please contact Harold Ogren or Greg Haffner with questions before camp.**

**Campers Initials:** \_\_\_\_\_

**PARENTAL RELEASE FORM:**

In case of an emergency Parent or Guardian will be contacted first. **Please list a 2<sup>nd</sup> Contact in case parents are not available.**

Name \_\_\_\_\_ Phone #(\_\_\_\_\_)\_\_\_\_\_

**Medical Information**

1. Does your child have any chronic medical problems or **medical dietary restrictions**?  
Yes \_\_\_\_\_ No \_\_\_\_\_ Please list any allergies or **medically necessary** dietary needs: (ie, nuts, bee sting, gluten free, dairy free, vegetarian). We will honor **medically necessary dietary needs**. \_\_\_\_\_  
\_\_\_\_\_

2. Does your child take any medications that need to be administered at camp? Medication will be turned in to our EMT/Medical personnel to be administered per dosing instructions.  
Yes \_\_\_\_\_ No \_\_\_\_\_ If Yes, list name of medication and condition it is for.  
\_\_\_\_\_

**Insurance**

The following information will be needed should treatment become necessary.

Is your child insured: Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please supply the following information

Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_

Name of person insured \_\_\_\_\_ Plan # \_\_\_\_\_

**Authorization of consent to the treatment of a minor:**

(I) (We), the undersigned, parent(s) or legal guardian of \_\_\_\_\_, a minor, do hereby authorize Sis-Q-Meadows Camp Staff member as an agent for the undersigned, to consent to and authorize X-Ray examination, anesthetic, 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 surgeon licensed under the provision of the Medical Practices Act on medical staff of any 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, to provide authority and power on the part of the aforesaid agent to give specific consent to any and all such diagnosis, treatment or hospital care which aforementioned physician in the exercise of his/her best judgement may deem advisable.

(I)(We) hereby authorize any hospital which has provided treatment to the above-named minor to surrender physical custody of said minor to the above-named agent upon the completion of treatment.

(I)(We) understand and agree that payment of any medical or dental care is (my) (our) responsibility.

\_\_\_\_\_  
Parent or Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent or Legal Guardian

\_\_\_\_\_  
Date