KALAHARI RETREAT

CHURCH RELEASE FORM

PARENTS AUTHORIZATION FOR MEDICAL AND SURGICAL CARE

This student is in good health and not suffering from any illness that would prevent him/her from participation in normal activity. I hereby authorize retreat leader to call an authorized doctor to administer medical aid and treatment at any time when they believe an emergency exists.

Parent/Guardian Signature: ________________________ Date: ________

Hospital Plan: ____

Policy/Group Number: ____

Allergies: ____

____

Last Tetanus Shot: ____

STUDENT COMMITMENT

I agree to have a good attitude, be respectful of all leaders, and to follow all rules laid out at the retreat. I understand that failure to abide by these guidelines may result in the loss of privileges or removal from the retreat.

Student signature: ____

BASIC INFORMATION

Kalahari Retreat '19
Registration/Medical Form

CHURCH NAME: _________________________________

Name: ____
(Last) (First) (M.I.)

Gender: ☐ M ☐ F Date of Birth: ___________ Grade: ____

School: ____

Adult T – Shirt size: ________

People I would like to room with: _______________________

____

Parent or Guardian: ___________________________________

Address: ____

City: ________________________ State: ______ Zip: ____________

Phone: _______________________ Cell: ________________________

Email: ____

Emergency Contact: ____________________________________

Relationship: ________________________ Phone: ________________