

# Community of Christ Event Release

Event: Hispanic Youth Retreat 2008- Camp Sionito - Bandera, Texas

## GENERAL INFORMATION

Name \_\_\_\_\_ Age \_\_\_\_\_ Grade Completed \_\_\_\_\_ Gender: Female Male  
Social Security Number \_\_\_\_\_ Phone Number ( ) \_\_\_\_\_ E-mail \_\_\_\_\_  
Address \_\_\_\_\_ City/State or Province \_\_\_\_\_  
Zip/Postal Code \_\_\_\_\_ Roommate Preference \_\_\_\_\_  
Religious Affiliation \_\_\_\_\_ Home Church \_\_\_\_\_  
Name of Parents, Custodial Parent, or Legal Guardian\* \_\_\_\_\_  
Work Phone \_\_\_\_\_ E-mail \_\_\_\_\_  
Additional Parent, Legal Guardian, or Next of Kin\* \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ E-mail \_\_\_\_\_  
Persons allowed to pick up child from event\* \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\*Applies only to those under 21 years of age.

## Emergency Notification

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone ( ) \_\_\_\_\_  
Address \_\_\_\_\_  
City/State or Province \_\_\_\_\_ Zip/Postal Code \_\_\_\_\_  
Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone ( ) \_\_\_\_\_  
Address \_\_\_\_\_  
City/State or Province \_\_\_\_\_ Zip/Postal Code \_\_\_\_\_

## Medical Information

Allergy to foods, medications (if none, so state) \_\_\_\_\_  
Is applicant currently under a physician's care for any acute or chronic medical condition? \_\_\_\_\_  
If yes, please explain. \_\_\_\_\_  
Does applicant carry *non-prescription* medication on their person? (if none, so state) \_\_\_\_\_  
Medication(s) and purpose \_\_\_\_\_  
Does applicant require *prescription* medications? (if none, so state) \_\_\_\_\_  
Medication(s) and purpose \_\_\_\_\_  
\_\_\_\_\_  
Physician \_\_\_\_\_ Phone ( ) \_\_\_\_\_  
Office Address \_\_\_\_\_  
Hospital/Clinic of Choice (if applicable) \_\_\_\_\_  
Health Insurance Provider \_\_\_\_\_ Phone ( ) \_\_\_\_\_  
Policy Holder's Name \_\_\_\_\_  
Address \_\_\_\_\_  
Group Number \_\_\_\_\_ Policy Number \_\_\_\_\_  
Other Information \_\_\_\_\_

**Please attach a copy of both sides of your insurance card.**

## Health Information

Has applicant ever had any of the following? (Please check if yes and provide month and year of latest occurrence.)

- |   |  |   |  |
|---|--|---|--|
| <input type="checkbox"/> anemia_____              | <input type="checkbox"/> appendicitis_____ | <input type="checkbox"/> asthma_____          | <input type="checkbox"/> bronchitis_____     |
| <input type="checkbox"/> chicken pox_____         | <input type="checkbox"/> diabetes_____     | <input type="checkbox"/> epilepsy_____        | <input type="checkbox"/> frequent colds_____ |
| <input type="checkbox"/> fractures(describe)_____ |  | <input type="checkbox"/> heart trouble_____   | <input type="checkbox"/> heart murmur_____   |
| <input type="checkbox"/> HIV_____                 | <input type="checkbox"/> hepatitis_____    | <input type="checkbox"/> kidney trouble_____  | <input type="checkbox"/> measles_____        |
| <input type="checkbox"/> mumps_____               | <input type="checkbox"/> pneumonia_____    | <input type="checkbox"/> rheumatic fever_____ | <input type="checkbox"/> scarlet fever_____  |
| <input type="checkbox"/> sinusitis_____           | <input type="checkbox"/> sore throats_____ | <input type="checkbox"/> tuberculosis_____    | <input type="checkbox"/> whooping cough_____ |
| <input type="checkbox"/> other_____               |  |   |  |

Please list applicant's major operations or serious injuries (describe and give dates):\_\_\_\_\_

Please list applicant's immunization dates for the following (or attach a copy of health card):

- |                    |                         |                      |               |
|--------------------|-------------------------|----------------------|---------------|
| DPT_____           | booster diphtheria_____ | booster tetanus_____ | smallpox_____ |
| typhoid_____       | tuberculin_____         | measles_____         | mumps_____    |
| polio vaccine_____ | other_____              |                      |               |

What contagious disease(s) has the applicant been exposed to recently?\_\_\_\_\_

Please check any of the following conditions that apply to the applicant:

- |  |   |                                      |                                   |                                   |
|--|---|--------------------------------------|-----------------------------------|-----------------------------------|
| <input type="checkbox"/> vision problems | <input type="checkbox"/> hearing problems | <input type="checkbox"/> hernia      | <input type="checkbox"/> fainting | <input type="checkbox"/> diarrhea |
| <input type="checkbox"/> constipation    | <input type="checkbox"/> sleep-walking    | <input type="checkbox"/> bed-wetting |                                   |                                   |

recent emotional upset — death of loved one, divorce of parents, please explain:\_\_\_\_\_

Please describe any other medical, emotional, psychological, dietary, or physical conditions that could affect the applicant's experience at event:\_\_\_\_\_

## Permission for Medical Treatment

I, the undersigned parent, legal guardian, next of kin, or applicant, hereby authorize any necessary medical treatment for this applicant/myself. I also guarantee payment of all charges incurred during this medical treatment.

Parent/Guardian Signature/Applicant\*\* \_\_\_\_\_ Date \_\_\_\_\_

## Photo Release

In consideration of the right of the applicant to participate in this event, I give consent to and authorize the taking of photographs or videotapes in which the applicant may appear. I waive all right of privacy in and to any said photographs or videotapes.

Parent/Guardian Signature/Applicant\*\* \_\_\_\_\_ Date \_\_\_\_\_

## Activity Consent

I specifically consent to the applicants' participation in this event. I certify that the applicant has the necessary skills to participate in any of the approved activities (e.g., if boating is approved, the camper can swim). I specifically do **NOT** want the applicant to participate in the following activities:\_\_\_\_\_

Parent/Guardian Signature/Applicant\*\* \_\_\_\_\_ Date \_\_\_\_\_

## Liability Release

*The undersigned parent, legal guardian, next of kin, or participant acknowledges that even though every effort is made to provide a safe, accident-free environment, incidents may occur. In consideration for being accepted by \_\_\_\_\_ Congregation/District/Stake/Region/Mission Center, Community of Christ, or participation in this event, we (I), being 21 years of age or older, do for ourselves (myself) (and on behalf of my child-participant, if said child is not 21 years of age or older) hereby release forever, discharge, and agree to hold harmless the camp and the Community of Christ, and the directors thereof from any and all liability, claims, or demands for personal injury, sickness, or death, as well as property damage and expenses of any nature whatsoever which may be incurred by the undersigned and the child-participant that occur while said child is participating in this event. Furthermore, we (I) (and on behalf of my child-participant, if under the age of 21 years) hereby assume all risk of personal injury, sickness, death, damage, and expense as a result of participation in recreating and work activities involved therein. Further, authorization and permission is given to said organization to furnish any necessary transportation, food, and lodging for this participant. The undersigned further agrees to hold harmless and indemnify said organization, its directors, employees, and agents, for any liability sustained by said organization as the result of negligent, willful, or intentional acts of said participant, including expenses incurred attendant thereto. **Both parents must sign unless parents are separated or divorced, in which case custodial parent must sign. \*\*Only applicant must sign if 21 years of age or older.***

Parent/Guardian Signature/Applicant\*\* \_\_\_\_\_ Date \_\_\_\_\_

Parent/Guardian Signature/Applicant\*\* \_\_\_\_\_ Date \_\_\_\_\_