

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 '20
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: _____

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