## Do not mail back. Amount Paid $\_\_\_\_\_\_\_\_\_\_\_\_

## Bring to Camp.

Amount Due $ \_\_\_\_\_\_\_\_\_\_\_\_

## 

# YOUTH CONSENT FORM

# Registration, Medical Release & Information

**INDIAN SPRINGS HOLINESS CAMP MEETING (July 13 - 23, 2017)**

**This form must be completed by:**

* All Campers who register to stay in the dormitories regardless of your age.
* All Campers who participate in supervised recreation regardless of your age.
* All Campers over 18 years of age and still on their parents’ insurance - a parent must complete this form.

## Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_Age: \_\_\_\_\_\_\_\_ Sex: M F Date: \_\_\_\_\_\_\_\_\_\_

First Last

## Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State: \_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_

## Dormitory Registration ($20 per Day). Indicate the days you plan to spend the night in the Dorm and/or eat a meal in the Cafeteria:

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Thurs | Fri | Sat | Sun | Mon | Tues | Wed | Thurs | Fri | Sat |
|  |  |  |  |  |  |  |  |  |  |

**Parental Consent:**

I give permission for my child to attend Indian Springs Holiness Camp Meeting. I understand that if my child is covered by health insurance coverage, the information must be shown below.

Should the need arise, I give permission for my child to be taken to a doctor/hospital for medical treatment and authorize the Holder of this form to consent to treatment.

I hereby release and agree to indemnify Indian Springs Holiness Camp Meeting from any and all liability for injury arising out of my child’s participation in this camp meeting.

I have read the above, understand it fully and sign it voluntarily. **E-Mail:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Parent’s Signature: ­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please List All Phone Numbers:**

**(h) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(w) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (c) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Camper’s Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Office Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Church Affiliation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pastor’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Church Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Church Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**City/State/Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

List below any allergies to medication or other problems of which the adult in charge should be made aware:

List all medications presently being taken: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HEALTH INSURANCE**: Company Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone # to obtain Pre-certification #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone # to verify Benefits: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CONTACT INFORMATION:**

**To contact Mat Luce:** [m.luce24@gmail.com](mailto:m.luce24@gmail.com) Mat’s Cell: (865) 607-1777

**To contact Iris Luce**: [dewdrop1218@me.com](mailto:dewdrop1218@me.com)