Capital University Youth Retreat
REGISTRATION AND EMERGENCY INFORMATION

Youth Name_____ Grade_____
Age_____ Gender Identity_____ Guardian Name(s)_____
Address_____City_____Zip_____
Cell Phone_____ Email_____
Home Congregation_____
Pastor/Deacon/Youth Group Leader_____

Dietary Restrictions (if any): _____
_____

Facts concerning the youth's medical history including allergies, medications being taken, and any physical impairments to which a physician should be alerted **(If taking medications, please list medication, dosages, times taken and any side effects participant may experience from their medication):**

_____
_____

Emergency phone numbers, please fill in the numbers that are applicable.
Guardian's Name_____
Guardian's Phone Number _____ Alternate Phone _____
Guardian's Name_____
Guardian's Phone Number _____ Alternate Phone _____

People to contact in the event of an emergency, if a guardian cannot be reached.
Neighbor/Relative_____Phone_____
Neighbor/Relative_____Phone_____

Please provide any additional information that you would like for us to be aware of concerning your child:_____
_____

I understand that my child will be responsible for their own medication, if needed, without supervision. (Note: if the child cannot self-medicate, they are ineligible to attend the retreat). I hereby certify that my child is physically able to participate in the Youth Retreat and I know of no restrictions which limit their participation in this program.

Today's Date_____ Signature of Legal Guardian_____

EMERGENCY AUTHORIZATION

In the event that an illness or injury would occur, I understand that every reasonable attempt will be made to contact the legal guardians listed above. However, I hereby authorize and consent to medical treatment for my child in case of injury or illness while attending the Youth Retreat.

In the event of an emergency and if I cannot be reached, Capital University has permission to secure emergency transportation for my child in the event of an illness or injury which requires emergency treatment. The emergency transportation service will determine the facility to which my child will be transported.

PLEASE TURN THIS PAPER OVER AND COMPLETE THE BACK SIDE, THANK YOU!

I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes to the appropriate medical care provider. I understand that it is my responsibility to pay my child's medical bill. I understand that Capital University does not provide medical insurance to cover emergency care or medical treatment of my child. I certify that my child is covered by adequate insurance to cover any personal injury that may be sustained while participating in this Youth Retreat. As applicable, I am responsible to submit any claims to my health insurance company for reimbursement.

Today's Date_____ Signature of Legal Guardian_____

LIABILITY RELEASE

I understand all reasonable safety precautions will be taken at all times by Capital University and its agents during the events and activities. I understand the possibility of unforeseen hazards and know the inherent possibility of risk. I hereby release, hold harmless, and forever discharge Capital University, its trustees, officers, agents, employees, students, representatives and volunteer staff from and against all claims, demands, and actions or causes of action, including for loss or damage to personal property, personal injury or death which may result or be incurred by the child listed on this form as a result of participation in this program.

Today's date_____ Signature of Legal Guardian_____

PROMOTIONAL RELEASE

I understand that Capital University may take photographs/videos of participants at the youth retreat. I consent to the use of any videotapes, photographs, slides, audiotapes, or any other visual or audio reproduction in which my child may appear by Capital University. I understand that these materials are being used for promotion of the programs of Capital University. My consent includes but is not limited to the University's website.

I release Capital University from any liability connected with the use of my child's picture or voice recording as a part of any promotional, recruitment, or fundraising program.

Today's date_____ Signature of Legal Guardian_____

PERMISSION TO ATTEND

I give _____permission to attend the Capital University Youth Group Retreat on January 31st and February 1st, 2020

GUARDIAN NAME (printed)_____

Signature_____ **Date**_____

Payment Method: **Check** (enclosed) __ **Cash** (due at check-in) __ **Credit** (due at check-in) __