

YOUTH WORKERS RETREAT REGISTRATION FORM

Please fill in all information so that we are able to better serve you.

Please print clearly.

Participant Role (please circle one): Staff Volunteer

Name _____

Address _____

City/State _____

Birth Date _____

Home ph. (____) _____

Cell ph. (____) _____

E-Mail _____

Local Church _____

Special Dietary or Other Needs _____

The cost for this event is FREE!

MAIL TO:

Youth Workers Retreat

P.O. Box 980250

West Sacramento, CA 95798-0250

Ph: 916.374.1528

Fax: 916.372.5544

E-mail: sharis@calnevumc.org

Web: www.cnumc.org/youthministries

ADULT MEDICAL FORM

The following information is required for all adult participants. Information is confidential and will be made available only to those adults who are directly responsible for the participant's care. *For their safety and well-being, **no participant will be allowed to be part of the event without a completed and signed Medical Authorization and History Form.***

IN CASE OF AN EMERGENCY, PLEASE CONTACT:

Name _____ Relationship _____

Home Phone () _____ Other Phone () _____

Please list any allergies: _____

Taking any medications?: Yes No Please list: _____

Is the participant under the direct care of a physician? Yes No

Please explain: _____

Any medical conditions that the camp should be aware of?: _____

RELEASE STATEMENT

I, _____ the undersigned, do hereby authorize the adult leaders acting on behalf of the California-Nevada Annual Conference of The United Methodist Church, as agent, and working with other non profit agencies or the City of Sacramento, to consent to any examination, x-ray, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is rendered at the office of said physician or at said hospital. It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required but is given to provide authority and power on the part of our aforesaid agent(s), especially in case of emergency, to give specific consent to any such diagnosis, treatment, or hospital care which the aforementioned physician in the exercise of his or her judgment may deem advisable. I agree to pay for any medical, dental, surgical, or hospital diagnosis, treatment, or care rendered to me.

Adult Volunteers Signature

Date