

Fall Retreat 2010  
**Registration and Waivers**  
Grace Community Church

NAME \_\_\_\_\_ AGE \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ ZIP \_\_\_\_\_ PHONE (\_\_\_\_) \_\_\_\_\_

IN EMERGENCY, NOTIFY \_\_\_\_\_ PHONE (\_\_\_\_) \_\_\_\_\_

DOCTOR \_\_\_\_\_ PHONE (\_\_\_\_) \_\_\_\_\_

**FALL RETREAT SCHEDULE AND ACTIVITIES:**

(refer to "Retreat 2010 Info" document posted on-line at [www.onewaystudents.org](http://www.onewaystudents.org))

**HEALTH HISTORY:**

Allergies: \_\_\_ Insect Stings \_\_\_ Medications \_\_\_ Foods \_\_\_ Other Allergies

Other: \_\_\_\_\_

Conditions: \_\_\_ Heart Condition \_\_\_ Frequent Colds \_\_\_ Chronic Asthma

\_\_\_ Frequent Upset Stomach \_\_\_ Hay Fever \_\_\_ Diabetes

\_\_\_ Physical Handicap \_\_\_ Dizziness \_\_\_ Other

If you checked any of the above, please give details (i.e., include normal treatment of allergic reactions): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Date of last tetanus shot: \_\_\_\_\_

Name and dosage of any medications that must be taken: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Any activity restrictions: \_\_\_ Yes \_\_\_ No

What restrictions?

\_\_\_\_\_

In the event that your child is injured or becomes sick while at camp and treatment at a medical facility is required, your medical insurance carrier will be billed.

Do you have health insurance? \_\_\_\_ Yes \_\_\_\_ No

If "yes," Name: \_\_\_\_\_

Policy Number: \_\_\_\_\_

Address: \_\_\_\_\_

**MEDICAL RELEASE:**

The person herein described has permission to engage in all Fall Retreat activities except as noted. I hereby give permission to Grace Community Church (GCC) to provide routine health care, administer prescribed medications, and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. I give my permission to GCC to arrange necessary related transportation for my child. In the event that I cannot be reached in an emergency, I hereby give my permission to the physician or dentist selected by the GCC leadership to hospitalize, to secure proper treatment, and/or order an injection, anesthesia, or surgery for my son or daughter as deemed necessary.

**LIABILITY RELEASE:**

Every activity sponsored by Grace Community Church is carefully planned and adequately supervised by adults. However, even with the best of planning and precaution, unforeseen events can occur. By signing this form, the parent or guardian agrees to release and discharge Grace Community Church, 1st Baptist Hilliard Retreat Center, all participating churches, and all employees or volunteer assistants that are related to the aforementioned organizations from any claims, causes of action, costs, obligations, or financial responsibility resulting from or arising out of any incident, injury or accident occurring while the minor listed is attending Summer Camp to include travel to and from Hilliard.

The parents or guardians understand that they are signing for the minor listed on this form and the signature is for both a medical and a liability release.

Parent or guardian's name (please print): \_\_\_\_\_

Parent or guardian's signature: \_\_\_\_\_ Date: \_\_\_\_\_