

I AM a CHILD OF GOD (JOHN 1:12)

2021 CONFIRMATION FALL RETREAT

Outlaw Ranch in Custer, SD

Saturday, Sept. 18 depart from Calvary at 10:30am

Sunday, Sept. 19 return to Calvary by 2 pm

STUDENT: _____ Student's Cell Phone _____

Parent(s): _____

I can transport (if needed): ____ (number) of students with seat belts for each

I can chaperone (if needed): YES _____ NO _____

Home Address _____ Zip Code _____ e-mail _____

My student will need:

Transportation: YES _____ NO _____

Scholarship: YES _____ NO _____ (Calvary has scholarships available, if needed)

I give permission for (Student's Name) _____ to participate in the activities of Calvary's Confirmation Retreat. I agree that the church or its personnel will not be held responsible for any accident that may occur. In the event I cannot be reached in an emergency, I give permission to the physician, selected by the adult leader in charge, to hospitalize, secure anesthesia, to order injections, or surgery for my child.

Parent/ Guardian Signature _____ Date _____

Cell Phone _____ Home Phone _____ Work Phone _____

Family Doctor is _____ Phone _____

Emergency contact person(s) other than parents: _____ Phone _____

INCLUDE \$70 REGISTRATION FEE WITH THIS FORM

Checks to: *Calvary Lutheran Church.*

Return this form along with payment to the church office *no later than:*

WEDNESDAY, SEPTEMBER 15

Please complete other side of this form!

Optional Activity/ \$20:

Horseback Trail Rides

YES NO

**OUTLAW RANCH & NESODAK
RETREAT PARTICPANT INFORMATION AND PERMISSION FORM**

RETREAT: Calvary Confirmation Retreat DATE OF RETREAT: September 18-19, 20

NAME: _____

HOME ADDRESS: _____

PHONE NUMBER: _____ BIRTHDATE: _____ SEX: _____

PARENT OR GUARDIAN (if minor): _____

ADDRESS: _____

PHONE – DAY: _____ EVENING: _____ CELL: _____

INSURANCE NAME & POLICY NUMBER: _____

FAMILY PHYSICIAN: _____ PHONE: _____

IN CASE OF EMERGENCY PLEASE NOTIFY:

Name: _____ Relationship: _____

Phone: Day _____ Night _____ Cell _____

Any time health care outside the camp community is needed parents & guardians will be notified. If you wish to be notified in ANY OTHER circumstances, please list here _____

LIST ANY CONDITIONS YOU MAY HAVE:

Dietary restrictions: _____

Any known allergies: _____

Description of any recent or current physical or mental conditions requiring special restrictions, treatment, or considerations while at camp: _____

Retreaters are responsible for taking their own medications. Adult advisors can handle/hold the medications for minors if parents/guardians would prefer.

Medications to be given at camp: _____

Any over-the-counter medications NOT to be taken at camp: _____

This health history is correct so far as I know, and I understand the risk in engaging in all prescribed camp activities. **Authorization for Treatment:** I hereby give permission to the camp health care personnel to provide routine health care, and to the medical personnel selected by the camp director to order X-rays, routine tests, treatment, and necessary transportation for me or my child; and, in the event I can't be reached in an emergency, to secure and administer treatment, including hospitalization, for me or my child. I give permission for my or my child's photo to be used for publicity purposes.

Signature of Parent/Guardian

Or Adult Camper: _____ Date: _____

