Registration Form

Please Circle one: Sponsor Student **Grade: 3rd/4th/5th/6th**

Name: _____ **M/F** **Birthday:** ____/____/_____
Street Address: _____
City: _____ **State:** _____ **Zip:** _____
Email Address: _____ **Home Phone:** _____

Church attending with: _____ **City/State:** _____
Main Contact of Group: _____ **Cell Phone:** _____

EMERGENCY CONTACTS

1. _____ Relationship: _____ Phone:_____
2. _____ Relationship: _____ Phone:_____

IN CASE OF EMERGENCY: I hereby give authorization to an adult leader of the youth group my child is with and/or a member of the leadership of Camp Illiana or Winterfest, as agent for me, to consent to an X-ray examination; medical, dental, or surgical diagnosis; treatment; and hospital care advised and supervised by a physician, surgeon, or dentist (as appropriate) licensed to practice under the laws of the state where the services are rendered, either at a doctor's office or in any hospital. I expect to be contacted as soon as possible.

This is also to certify, to the best of my knowledge, that the above named has no physical handicaps or illnesses (except as noted on this form). I hereby release Camp Illiana and its staff, Winterfest and its staff, the church and staff that my child is attending with and sponsors from responsibility and liability for any injury or illness that the above named may sustain during the Winterfest event.

Winterfest staff assumes responsibility for discipline during Winterfest and if necessary after discussion with group leader, may, because of misconduct or disobedience, require a student to leave. In such an instance, I assume responsibility for returning the student home.

I give permission for use of photo or video taken during Winterfest for promotional and event uses. I also give permission for my child to participate in off-campus activities around Washington, IN.

Signature of Parent/Legal Guardian: _____ Date Signed: _____

MEDICAL INFORMATION

Insurance Co: _____ Policy/Group #: _____
Policy Holder's Name: _____ Phone: _____
Physician's Name: _____ Phone: _____

Allergies: _____ Medications: _____

Handicaps/limitations: _____