

**2011 YOUTH REGISTRATION FORM
ROCKY MOUNTAIN MISSION CENTER**

Community of Christ

NAME OF EVENT: _____ AMOUNT ENCLOSED: \$ _____

DATE(S) OF EVENT: _____ EVENT LOCATION: _____

PERSONAL INFORMATION

Name _____ Birthdate _____
(Last) (First) (Middle)

Grade _____ Phone _____ E-Mail _____

Address _____
(Street) (City) (State) (Zip)

Gender (M/F): _____ Congregation _____

Name of Parent or Legal Guardian _____

Home Phone _____ Work Phone _____

Additional Parent or Legal Guardian _____

Home Phone _____ Work Phone _____

Name(s) of person(s) other than parent to whom the camper may be released:

(Anyone who picks up campers must be at least 18 years old.)

1. _____ 2. _____

3. _____ 4. _____

EMERGENCY NOTIFICATION (Other than parent or guardian)

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

GENERAL HEALTH INFORMATION

Family Physician: _____ Phone: _____

Health Insurance Carrier: _____ Phone: _____

Name of Policy Holder: _____ Policy Number: _____

Date of Last Exam: _____

Please explain any "Yes" answers to the following questions.

Yes No Question

G G Does the camper have any restricted activities? _____

G G Is the camper allergic to any foods, medications, etc.? _____

G G Is the camper presently under a physician's care for any acute/chronic medical condition? _____

G G Are there other physical, emotional, medical or psychological concerns that need special attention? _____

G G Is the camper presently taking any medications? _____

IMPORTANT: A Medication Administration Authorization is REQUIRED if camper is under a physician's care for any medical condition or taking ANY medications (prescription or over-the-counter). ONLY IF PARENT OR LEGAL GUARDIAN IS NOT ATTENDING CONFERENCE.

PERMISSION FOR MEDICAL TREATMENT

In the event of a medical emergency, I, the undersigned parent, legal guardian or next of kin, understand every effort will be made to contact me or the emergency contact named on this form. If I cannot be reached, I hereby authorize any necessary medical treatment for this youth. I also guarantee payment of all charges incurred during this medical treatment.

PERMISSION FOR MEDICAL INFORMATION SHARING

I, the undersigned parent, legal guardian or next of kin, give consent for my child’s health provider and church camp/retreat/activity personnel to discuss my child’s health concerns.

PHOTO RELEASE

In consideration of the right of the camper to participate in this activity, I give consent to and authorize the taking of photographs or videotapes in which the camper may appear. I waive all right of privacy in and to any said photographs or videotapes.

LIABILITY RELEASE

The undersigned parent, legal guardian or next of kin acknowledges that even though every effort is made to provide a safe, accident-free environment, incidents may occur. In consideration for being accepted by the COMMUNITY OF CHRIST for participation in this event, we (I), being 21 years of age or older, do on behalf of my child-participant hereby release forever, discharge, and agree to hold harmless the COMMUNITY OF CHRIST and its directors, agents, employees, assigns, and any subordinate units from any and all liability, claims or demands for personal injury, sickness, or death, as well as property damage and expenses of any nature whatsoever which may be incurred by the child-participant while participating in this event. Further, authorization and permission is hereby given to the COMMUNITY OF CHRIST to furnish any necessary transportation, food and lodging for this participant. The undersigned further agrees to hold harmless and indemnify said organizations, its directors, employees, and agents, assigns, and subordinate units for any liability sustained by said organizations as the result of the negligent, willful or intentional acts of said participant, including expenses incurred attendant thereto.

CAMPER BEHAVIOR

The camper will not attend retreat/camp if any illness at the opening day of retreat/camp should be harmful to him/her or to others. The camper will come fully prepared to participate in all activities other than those listed in the activity consent section. The possession or use of any tobacco, alcohol or illegal drugs, video or electronic games, large knives or other weapons will not be tolerated. The camper may be sent home, at the expense of the undersigned, as a result of misbehavior or violation of retreat/camp policies.

We strongly encourage you not to bring electronic equipment to activities. Please be aware each camp director has individual polices regarding the use of electronics and signature of this form implies compliance by both parents and campers.

Camper Signature: _____ DATE: _____

Parent/Guardian Signature: _____ DATE: _____

Please complete this form and send to:
Rocky Mountain Mission Center Office
9501 Lou Dr
Denver, CO 80260, Fax: 303-426-5900

**MEDICATION ADMINISTRATION AUTHORIZATION FORM
ROCKY MOUNTAIN MISSION CENTER**



NAME OF YOUTH: _____ BIRTHDATE: _____

I, the undersigned parent, legal guardian or next of kin, for my child, ask the Community of Christ staff give medication(s) to my child, according to the Health Care Provider's signed instructions on the lower part of this form.

Prescription medications must come in a container labeled with: child's name, name of medicine, time medicine is to be given, dosage, date medicine is to be stopped, and licensed health care provider's name. Pharmacy name and phone number must also be included on the label.

Over-the-counter medications must be labeled with child's name. Dosage must match the signed health care provider authorization, and medicine must be packaged in original container.

Preventive creams/ointments/sunscreen may be applied unless skin is broken or bleeding
_____ (initials)

By signing this document, I give permission for my child's health care provider to share information about the administration of this medication with the authorized staff person delegated to administer medication.

Print Parent/Legal Guardian's Name Signature of Parent/Legal Guardian Date
Day Phone: _____ Evening Phone: _____



HEALTH CARE PROVIDER AUTHORIZATION

Medication – Name: _____
Dosage: _____ Route: _____
Times to be given: _____
Special Instructions: _____
Side effects that need to be reported: _____

Medication – Name: _____
Dosage: _____ Route: _____
Times to be given: _____
Special Instructions: _____
Side effects that need to be reported: _____

Print Health Care Provider Name Signature of Health Care Provider Date
With Prescriptive Authority With Prescriptive Authority

License Number: _____ Phone: _____