

**Fall Retreat
October 15 - 17, 2010**

Name _____
Address _____

Age/Grade _____ / _____
Phone _____
Home Church _____
Email: _____

In Case of Emergency:

Name _____
Relationship _____
Phone: _____

Name _____
Relationship _____
Phone: _____

Registration: \$32 per person

T-Shirt: \$8 (optional)

Your Total: \$ _____

T-Shirt Size: _____ (adult: S, M, L, XL, XXL)

Make Checks Payable to Ridgeview Christian Church,
With "Fall Retreat" noted on Memo Line

Registration Forms and Money ***DUE*** OCT, 1st

Send Form and Payment to:

Ridgeview Christian Church

Attn: Fall Retreat

PO Box 338

Rolla, MO 65402

No refunds after Oct 1st, 2009

**LEGAL AGREEMENT WITH GUARDIAN & CONSENT FOR
MEDICAL TREATMENT OF A MINOR**

It is necessary for the parents to assume the responsibility for the applicant. Below is a legal agreement for this purpose which the parent or guardian must sign and return **BEFORE THE EVENT**.

I, _____
(NAME)

of, _____
(ADDRESS)

do hereby state that I am the parent or legal guardian of:

_____ a minor, age _____,
(CHILD'S FULL NAME)

Born: ____ / ____ / ____
(Date of Birth)

In consideration of the acceptance of the above applicant we covenant and agree with Gasconade Christian Service Camp that we will at all times hereafter indemnify, keep indemnified and save harmless the said GCSC, or which it may be brought against or claimed against the GCSC or which it may pay, sustain, or incur as a result of illness, accident, or misadventure to the above applicant, during the period the said applicant is a participant in the Fall Retreat. In case of an accident or sickness, I hereby authorize the Weekend Dean and/or Camp Nurse and/or Adult Chaperone to sign consent for treatment of the applicant by a doctor, or be admitted to the hospital. I will be personally responsible for expenses incurred for reasonably necessary medical treatment for the applicant.

This is effective for the date(s) of October 15 - 17, 2010.

Dated this ____ day of _____, 20__.

(X) Guardian's signature _____

Medical Insurance Carrier _____

Identification No. _____ Exp. Date _____

Family Doctor _____ Phone _____

Date of Last Tetanus Shot _____

Medications _____

Restrictions _____