Security

28th Annual
SMBC Fall Retreat
Oct 6-8, 2017

Name_____
Address_____
_____
Age_____**Sex**_____
Phone_____
Church_____
T-Shirt Size: **Grade:**_____
S M L XL XXL XXXL **(grade 7-12 only)**
(registration must be rec'd by Sept. 26th to guarantee size)
In Case of Emergency:
Name_____
Relationship_____
Phone_____

Registration Fee: **$30**
***Make checks payable to Central Church of Christ**

Mail to: **Central Church of Christ**
Attn: Fall Retreat
1402 12th St
Bedford IN 47421

Registration: 5-7 pm on Oct 6th
Pickup time: Noon on Oct 8th

Register early:
Attendance limited to the first 120 campers

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 with the application.

I, _____of
(PARENT/GUARDIAN'S NAME)
_____ do
(ADDRESS)
hereby state that I am the parent or legal guardian of
_____ a minor, age_____, born_____.
(CHILD'S FULL NAME) (DOB)

In consideration of the acceptance of the above applicant we covenant and agree with Spring Mill Bible Camp that we will at all times hereafter indemnify, keep indemnified and save harmless the said Spring Mill Bible Camp, or which it may be brought against or claimed against the Spring Mill Bible Camp or which it may pay, sustain, or incur as a result of illness, accident, or misadventure to the about applicant, during the period the said applicant is a participant in the Spring Mill Bible Camp Fall Retreat. In case of an accident or sickness, I hereby authorize a Director or Infirmary Supervisor to sign a 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 dates of 6 October 2017 to 8 October 2017. Dated this ____ day of _____, 20___.

(X) Guardian's signature_____
Medical Insurance Carrier_____
Identification No._____Exp. Date_____
Family Doctor_____Phone_____
Date of Last Tetanus Shot_____No Top Bunk_____
Medications_____
Special Needs_____