

Permission for Medical Treatment

I, the undersigned parent, legal guardian, next of kin, or applicant, hereby authorize any necessary medical treatment for this applicant/myself. I also guarantee payment of all charges incurred during this medical treatment.

Photo Release

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

Activity Consent

I specifically consent to the applicant's participation in activities offered by this camp, including but not limited to camping, boating, canoeing, swimming, hiking, and sporting events. I have deleted any items from the preceding list to which I do NOT give consent for participation. I certify that the applicant has the necessary skills to participate in any of the approved activities (e.g., if boating is approved, the camper can swim). I specifically do NOT want the applicant to participate in the following activities:

Liability Release

The undersigned parent, legal guardian, next of kin, or participant acknowledges that even though every effort is made to provide a safe, accident-free environment, incidents may occur. In consideration for being accepted by Far West Mission Center, Community of Christ for participation in this event, we, being 21 years of age or older, do for ourselves (myself) (and on behalf of my child-participant, if said child is not 21 years of age or older) hereby release forever, discharge, and agree to hold harmless the camp and the Community of Christ and the directors thereof 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 undersigned or the child-participant that occur while said child is participating in this event. Furthermore, we (and on behalf of my child-participant, if under the age of 21 years) hereby assume all risk of personal injury, sickness, death, damage, and expense as a result of participation in recreating and work activities involved therein. Further, authorization and permission is given to said organization to furnish any necessary transportation, food, and lodging for this participant. The undersigned further agrees to hold harmless and indemnify said organization, its directors, employees, and agents, for any liability sustained by said organization as the result of negligent, willful, or intentional acts of said participant, including expenses incurred attendant thereto. A parent/guardian must sign release.

****Only applicant must sign if 21 years of age or older.**

Please sign Statement & Release on second page

Event name: _____

(ie. Senior High Camp, Rally, Retreat)

Far West Mission Center – Registration Form

website

Send this Completed Form to: Far West Mission Center, Camping Office, 5124 Faraon St.,
St. Joseph, MO 64506 – Phone: 816-232-3319

Name: _____
Last First Middle initial

Address: _____
Number and Street

_____ City Street/Province Zip/Postal Code

E-mail Address: _____

Camp _____
 Cost: _____ Deposit: _____
(minimum of \$50.00)
 Congregation Scholarship \$\$: _____
 Balance due: _____
 (Balance is due at Activity Start Date)

Parent(s)/Legal Guardian(s): _____

Daytime Telephone: _____
Area Code

Evening Telephone: _____
Area Code

Congregation _____
 Check the ONE that applies...
 Camper Staff

Sex: M F _____ Birthday
 _____ Grade Complete in school
 T-shirt Size: _____

Medical History – (Please explain any “Yes” answers)

- | Yes | No | Question | (Please Attach a Photocopy of Your Insurance Card) |
|--------------------------|--------------------------|--|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Are you allergic to any foods, medications, etc.? | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you presently under a physician’s care for any acute/chronic medical condition? | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you currently taking any medications? | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have any physical restrictions or emotional, medical or psychological conditions that need special attention? | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you recently been exposed to a contagious disease? | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Date of your last Tetanus shot? | _____ |

Family Physician: _____ Phone: _____

Office Address: _____

Health Insurance Company: _____ Phone _____

Policy Holder’s Name: _____

Group Number _____ Policy Number: _____

Daytime Telephone: _____

Next of Kin/Friend: _____ Evening Telephone: _____

Please check all releases being signed for: Medical Photo Activity Liability

Statement of Consent and Release

I, the undersigned, have read and consent to the rules, guidelines, and releases specified on the reverse of this form.

| | | |
|---------------------------------|-----------------------------------|------|
| Participant (If Age 21 or Over) | Parent/Legal Guardian/Next of Kin | Date |
|---------------------------------|-----------------------------------|------|