Young Adult Retreat at Camp Jo Ota

June 24-27 $185

Name _____ T Shirt Size _____

Permanent Address _____ DOB _____

Zip (mm/dd/yyyy)

Best
Phone # _____ Email _____

Students:
School Address _____

Street & Number

Best
Phone # _____ Email _____

Church Relationship

Current Church
(Congregation, denomination) _____ Member ___ yes ___ no

If yes, number of years _____

Pastor's Name _____ Phone _____

Church Address _____

List any other churches attended and or previous camp
locations and years attended. _____

DIET, NUTRITION: ☐ This participant eats a regular diet ☐ This participant eats regular vegetarian diet. ☐ This participant has special food needs.

Please describe any special dietary needs below. If additional space is needed, please attach an additional sheet.

Authorization and Release of Information

I authorize any persons, congregations, or other organizations listed by me here to give to the offices of the Northeast & Ozark Areas of the Christian Church (Disciples of Christ) of Mid-America Region (and/or its Areas), any information they may have regarding my character, experience, and fitness for work with children or youth

In consideration of the receipt and evaluation of this information given by me here, I hereby release the Christian Church (Disciples of Christ) of the Mid-America Region Missouri Union Presbytery , its agents, successors, and administrators from any and all claims, actions, causes of action, demands, rights, damages, costs, loss of service, expenses and compensation whatsoever which may at any time result from the use of the information provided by the above referenced persons, congregations, or other organizations listed by me.

laid and volunteer staff, including but not limited to searches of state and federal sex offender databases, criminal records, and child/elder abuse registries.

Photography Release: I consent to be photographed while participating in camp or trip activities and for photos to be used during camp and afterward for educational and promotional activities.

The information supplied by me in the foregoing Application is true and correct to the best of my knowledge. I have read the foregoing Authorization, and Release and fully understand it.

Signature _____

Date _____

Brief Health History **Date of Last Physical Exam** _____

Name: _____ Date of Birth: _____

Address: _____ City/State/Zip: _____

Home Telephone: ( )_____ Cell Phone: ( )_____

E-mail Address: _____

In case of emergency, notify: _____ Relationship: _____

Complete Address: _____

Daytime Phone: ( )_____ Evening Phone: ( )_____

Insurance Information: Is the participant covered by medical/hospital insurance ☐ Yes ☐ No

If so, indicate carrier or plan name: _____ Policy/Group #: _____

Physician: _____ Phone: ( )_____

Dentist: _____ Phone: ( )_____

Date of Last Tetanus Shot: _____

ALLERGIES List all known include medicines, food, insect stings or bites, hay fever, asthma, animals, etc.	**Describe reaction and management of reaction** if more space is needed, please attach an additional sheet

MEDICATIONS BEING TAKEN Please list all medication (including over-the-counter or non-prescription drugs) and bring enough to last the entire time at camp. All medication must be in the original package that identifies the patient, prescribing physician (if prescription drug), name of the medicine, dosage and frequency of administration. Staff meds will be stored in regular meds storage or in Nurse or Director room. If more space is needed, please attach an additional sheet.

Medication & Dosage.	**When given & reason for taking medication**

Please list any Previous or Regularly Occuring medical Conditions including eyewate and hearing assitded devices

_____

_____

_____

_____

_____

Use this space for any additional information about participant's physical, mental, or emotional health about which the camp should be aware. If more space is needed, please attach an additional sheet.

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