2019 PUNK

REGISTRATION FORM/PERMISSION SLIP/MEDICAL FORM

Name of PUNK: ____

Age: ______________ Year in School just completed: ______________________________

____ has my permission to attend the Rainbow Trail DAY CAMP events, a program of Trinity Lutheran Church of Boulder, CO, from June 24-28, 2019. This includes permission to attend all field trips and camp activities.

I/we hereby appoint those in charge, should they not be able to contact me, to act as my agent and authorize them to secure at my expense any emergency or other necessary medical and/or surgical treatment
that may have to be rendered to my child during this 5-day church program. I/we further agree to release, hold harmless, and indemnify the church and anyone acting on my behalf or on their behalf from any and all liability for selecting or securing any medical or surgical treatment.

I/we fully know of and understand what perils are or could be involved in this church program and consent to have the above-named child fully participate and engage in all activities directly or indirectly related to this program; and further agree to assume on my/our behalf and on behalf of the above-named child any and all risks or perils directly or indirectly related to this program. I/we further state that we know what training and education the above-named child must have to fully participate in this program and that the above-named child has the necessary training and knowledge to so participate. I/we know that this program will be conducted by Trinity Lutheran Church of Boulder, CO., not-for-profit organization, and I/we hereby release on my behalf and on my child's behalf Trinity Lutheran Church and its agents from any and all liability arising out of this DAY CAMP experience.

Parent's signature: Father ____
(only one parent necessary)
Mother ____

Home address ____

Phone (Home) Mother ________________________ Father ____________________________

(Cell) Mother ________________________ Father ____________________________

In Case of emergency contact: ____

Relation to above-named child ____________________________Phone ____________________

Name of family doctor: ____

Phone (office): ____

Insurance Carrier: ____________________________________Phone: ______________________

Policy Number: ________________________________ Group Number: ____________________

PLEASE LIST MEDICATIONS OR MEDICAL CONDITIONS: