FCF Spring Parley 2019

June 7-8, 2019 (cost $30)

Arrive at camp anytime between 3-7pm

Evergreen Sportsman Club

12736 Marksman Rd SW Olympia, WA 98512

ADULT REGISTRATION

PLEASE FILL OUT ONE FORM FOR *EACH ADULT* ATTENDING
*****PLEASE PRINT CLEARLY****

NAME:_____ **PHONE:** __ __ __ - __ __ __ - __ __ __ __ __

ADDRESS:_____

EMAIL ADDRESS: _____

EMERGENCY CONTACT: NAME_____ **PHONE:**_____

NAME_____ **PHONE:**_____

LIABILITY RELEASE for GATEWAY FELLOWSHIP

I acknowledge that participation in the activity described above involves risk to the participant and may result in various types of injury including, but not limited to, the following: sickness, bodily injury, death, emotional injury, personal injury, property damage or financial damage. In consideration for the opportunity to participate in royal rangers or girls ministries, the participate or parent/guardian acknowledges and accepts the risks of injury associated with participation. The participate or parent/guardian accepts personal financial responsibility for any injury or other loss sustained during the activity, as well as for any medical treatment rendered to the participate that is authorized by Gateway fellowship or its agents, employees, volunteers or any other representatives (collectively referred to hereinafter as the "Activity Sponsor"). Further, the participant or Parent/Guardian releases or promises to indemnify, defend, and hold harmless the Activity Sponsor for any injury, property loss or illness arising directory or indirectly out of the described activity whether such injury arises out of negligence of Activity Sponsor, the Participate or otherwise.

Parent Signature_____

OFFICE USE ONLY: ❑FEES ❑REGISTRATION ❑ RELEASE ❑EMERGENCY CONTACT

❑Cash_____ **❑Check #**_____

PLEASE TURN OVER

HEALTH HISTORY AND MEDICAL PERMISSION FORM

*****PLEASE PRINT CLEARLY****

Have you ever been treated for any of the items listed below:

❑ Heart disease ❑ Asthma ❑ Seizures ❑ Allergies

❑ Bronchitis ❑ Diabetes ❑ High Blood Pressure

PLEASE Provide additional information about any item checked above.

_____

_____

Please identify any physical impairment or limitations

_____

_____

Do you wear: (If yes check ❑)

❑ Contacts ❑ Glasses ❑ Dental Appliance

Please list any medications being taken: _____

_____

INFORMATION NEEDED IN THE EVENT OF HOSPITALIZATION

Name of policy holder: _____

Medical insurer: _____

Policy or Certificate #: _____

Employer: _____

Employer Group #: _____