Lakeside Winter Retreat **Camper Information / Permission and Release**

Group Name: ______________________ Group Leader's Name: ______________________

Dates of Attendance: ______________________

Name: ______________________ D.O.B. ______________ Gender______ Grade ______

Street Address: ______________________ Camper's Email ______________________

City: ______________________ State: __________ Zip Code: ______________

Parent/Guardian Name: ______________________	Parent/Guardian Name: ______________________
Home Phone #______________	Home Phone #______________
Cell Phone #______________	Cell Phone #______________
Email: ______________________	Email: ______________________

Permission Statement

I understand and certify that my child's participation in Lakeside Christian Camp's Winter Retreat activities is completely voluntary and I have familiarized myself with the camp's program and activities in which my child will be participating. I recognize that certain hazards and dangers are inherent in the Winter Retreat programs and particularly, but not limited to activities in the snow, football, broom hockey, volleyball, basketball and polar bear swim. I acknowledge that although Lakeside has taken safety measures to minimize risk, Lakeside cannot guarantee that the participants, equipment, premises, and/ or activities will be free of hazards, accidents and / or injuries. I further recognize and have instructed my child in the importance of knowing and abiding by Lakeside's rules, regulations and procedures for the safety of camp participants. By signing, I also grant permission for the use of any photos taken of the participant named above in Lakeside promotional materials.

In an emergency, I hereby give permission to the physician or hospital selected by the camp director to hospitalize, secure the proper diagnostic, laboratory and radiological procedures, and to order any necessary medications, injections, anesthesia, intravenous therapy, or surgery for my child as named above.

______________________________________ ______________________

To be signed by parent or guardian for those under 18 Date

Medical Information:

Date of last Tetanus Shot: ______________________

Known allergies, medical problems or physical limitations:

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Person to contact in case of emergency (if parents not available): ______________________

Relationship: ______________________ Phone # ______________________

Insurance Information

Insurance Company______________________ Policy #__________________ Group # __________________

Name of Policy Holder: ______________________

If no insurance, I agree to pay for any necessary treatments ______________________ (signature)