

STRAIGHTFORWARD WINTER RETREAT 2012



FEBRUARY 17-20
PINE SUMMIT CAMP
BIG BEAR, CA

COST: \$160 (SCHOLARSHIPS ARE AVAILABLE)

REGISTRATION DEADLINE: FEBRUARY 3, 2012 (\$10 LATE FEE AFTER)

NEED MORE INFO? CONTACT BRANDON AT BJKATAGI@GMAIL.COM

REAL LIFE TESTIMONIALS:



I'M LIKE, SO
EXCITED GUYS!

OH MY GOSH!
ME TOO AYLA!



I'M EXCITED TOO. BUT IN
A QUIET, MANLY WAY



I REALLY HOPE
IT SNOWS!

Winter Retreat 2012

Name: _____ Phone#: _____

Address: _____

School _____ Grade: _____

Email Address: _____

(No Guarantees!)

I would like to be in a cabin with: _____

I have attended CBC Youth's Winter Retreat before: Yes [] No []

Special/Medical Concerns (allergies, illness, medication):

I would like to apply for a partial scholarship: Yes [] No []

If yes, please include a 1/2-1 page explanation of why you are applying for a scholarship.

Parent Consent:

I hereby give permission for my child to attend Cerritos Baptist Church's Youth Retreat at Thousand Pines Christian Camp. I understand that a current (2012), signed "Medical Release Form" and a Thousand Pines "Release and Consent Form" must be turned in to CBC Youth Ministry director Brandon Katagi.

PARENT/GUARDIAN SIGNATURE

PRINT NAME

DATE

Deadline: Please Sign Up by February 3
Any registrations received after this date will cost \$10 extra!

Staff Use Only

Date Received: _____

Scholarship requested

[] Yes

Amount Paid: _____

Amount: _____

[] Check

Approved: Yes No

[] Cash



Straightforward Youth Ministries

Jr. High and High School

Straightforward Youth Ministries Medical Release Form 2012

Cerritos Baptist Church 11947 Del Amo Blvd., Cerritos, CA 90703 562.860.1720
Authorization of Consent to Treatment of a Minor for Jan. 1st, 2012 to Dec. 31st, 2012

I (we), the undersigned, parent(s) or guardian of _____, a minor, do hereby authorize the adult youth advisor and youth leaders of Cerritos Baptist Church as agent(s) for the undersigned to consent to any x-ray examination, anesthetic, medical or surgical diagnosis, or treatment, and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of any physician, and surgeon licensed under the provisions of the Medical Practice Act, or the State of California, or the medical staff of any approved and licensed hospital whether such diagnosis or treatment is rendered at the office of the physician or hospital.

It is understood that this authorization is given in advance of any specific diagnosis, treatment of hospital care being required, but is given to provide authority and power on the part of the aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment, or hospital care which the physician in the exercise of his/her best judgment may deem advisable.

Name of Minor _____ Date of Birth _____

Address _____ City _____ State _____ ZIP _____

Home Phone # _____ Other Phone _____

Signature of Parent/Guardian _____ Date _____

Relationship to Minor _____

Health Insurance Company _____ Policy # _____

List any allergies to foods or medications that you have: _____

Are you taking any medications regularly? Yes ___ No ___

If so, please list: _____

Give the dates of your latest immunizations: Polio _____

Tetanus _____ Other _____

List any special medical concerns to be aware of: _____

Doctor/Physician who knows you best medically: Name _____

Phone # _____ Address _____

Emergency Contact: _____

Address _____ City _____ State _____ ZIP _____

Home Phone # _____ Other Phone _____