M4 Camps 2019

PARENTAL CONSENT AND MEDICAL INFORMATION FORM
Photo & Video Release

Participant's First Name_____ Middle_____ Last Name_____

Address_____ City_____ Zip _____

Home Phone ( )_____ Birthdate___/___/___

MEDICAL INFORMATION:

Does your child have an allergic reaction to penicillin? _____ To bee stings, bites, etc.?_____
To other medicines? _____ If yes, which ones _____

Is there any medical information you feel we should have concerning your child?
_____
_____

ALL MEDICINE MUST BE TURNED OVER TO THE CHURCH CHAPERONES BEFORE LEAVING!
EMERGENCY NUMBERS:
Doctor's Name _____Phone ( ) _____
Parent/Guardian's Name _____ Home Phone ( ) _____
Other Phone ( )_____

Place of Work _____Phone ( ) _____

Insurance Carrier _____ ID # _____
Address_____ City_____ St_____ Zip_____
Phone ( ) _____ Other numbers/info_____

M4 Ventures, LLC & Camps, & Waukaway Springs Christian Retreat Center are Christian organizations, and Christian standards of conduct, dress, and attitude are expected from each participant.

I GIVE MY CONSENT FOR MY SON/DAUGHTER TO PARTICIPATE IN M4 Kids' Camp. When it is deemed necessary for my son/daughter's health, the leaders may have my son/daughter hospitalized or use outside medical, surgical, or dental aid, in which case all such expenses shall be paid for by me. I shall in no way hold M4 Ventures, Waukaway Springs Christian Retreat Center, or its representatives responsible for any financial obligation. I understand that as a participant, my child may be photographed or videotaped during normal camp or event activities and these photos/videos may be used in promotional materials.

Parent/Guardian_____Date___/___/___