

Youth & Young Adult Retreat – April 19-21, 2024 – Camp Cedar Crest

Liability & Medical Release Form

FOR MINORS (6th grade–11 years to HS–17 and younger)



PARTICIPANT INFORMATION:

Participant Name _____ Age _____ DOB ____ / ____ / ____ M F

Address/City/Zip _____ Church: _____

If the participant has a phone, what is their phone number: _____

HEALTH INFORMATION: (Please submit a copy of your insurance card.)

Health Insurance Company _____ Policy Number _____

Known Allergies and Reactions / Medications Currently Taking _____

Other concerns related to the participant's physical condition: _____

PARENT(S) OR GUARDIAN INFORMATION:

Name(s): _____ Email(s): _____

Address/City/Zip (if different from participant's): _____

Phone(s): _____ Church: _____

Who to contact in case of emergency if the parent(s)/guardian cannot be reached:

Name _____ Relationship _____ Phone _____

Relationship _____ Phone _____

As the parent or legal guardian of the participant listed on this form, I certify he/she has my full approval to participate in the ABCOFLASH Youth & Young Adult Retreat taking place April 19-21, 2024, at Camp Cedar Crest. He/she is expected to abide by the retreat rules and be directly responsible to their church leader. If necessary, because of misconduct or disobedience, he/she may be asked to leave the retreat. I will assume full responsibility for returning the participant home in such an instance.

Further, I do release and hereby agree to hold blameless American Baptist Church of Los Angeles, Southwest & Hawaii (ABCOFLASH) and its employees and agents from any and every claim arising, or which may be asserted by me or by any member of my family because of participating in any activities associated with ABCOFLASH. I also release the lessor/owner of properties on which the Program is held. I agree to pay for any damages or property loss as determined by ABCOFLASH or Camp Cedar Crest.

Further, I do authorize the group leader or sponsor of this retreat (ABCOFLASH), in the event I cannot be reached by phone, to give consent to a physician and/or hospital for emergency medical or surgical treatment while on this trip. It is understood that I will assume any financial responsibility for any expense that may be incurred for said emergency treatment.

Further, I do certify that he/she is covered by adequate accident insurance.

My consent and signature is given below. I have read and agree to the information given in this entire form.

Printed Name of Parent(s)/Legal Guardian _____

Signature of the Parent(s)/Legal Guardian _____

Date _____