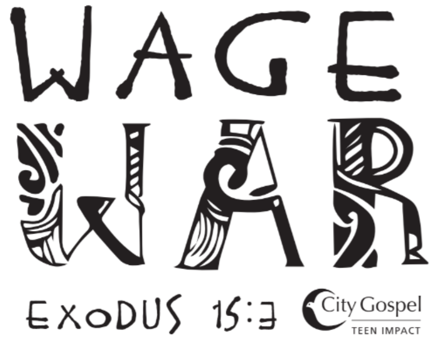

November 1-3, 2019

Kirkwood Camp & Conference Center

5719 St. Rt. 73 West Wilmington, OH 45177

Contact: Joe Dixon● jdixon@citygospelmission.org

PLEASE RETURN BY OCTOBER 13, 2019

Name: ____ Birth Date ____/____/____ Age: ____ Grade: _____

Sex: M or F Street Address: _______________________ City: _______________ State: _______ Zip Code:_______

Church: ______________________________________ Youth or Senior Pastor Name:___________________________

Student Cell Phone #: __________________________ Student Email: _________________________________

T-Shirt Size: XS S M L XL XXL (circle one)

Parent/Guardian Name: ____

Phone # 1: _________________________ Phone #2: __________________________

Can you receive text messages? If yes, on what phone number: _______________________________

Parent Email Address: ____

Can we text you retreat information? YES / NO (circle one)

Can we email you retreat information? YES / NO (circle one)

If parent/guardian is not available in an emergency, please notify:

Name: ___________________________ Relationship: _______________ Contact Phone #: ________________

Name:____________________________ Relationship: _______________ Contact Phone #: ________________

HEALTH HISTORY (please check if applicable)

Asthma_____ Hay Fever_____ Poison Ivy Allergy_____ Insect Sting Allergy_____ Frequent Ear Infections_____

Frequent Headaches_____ Frequent Sore Throats_____ Heart disease_____ Clotting Disorder_____ Seizures_____

Bedwetting_____ Fears/Phobias_____ Sleepwalking_____ Chicken Pox_____ Behavior Problems_____

ADD/ADHD_____ Speech/Vision Problem_____ Hepatitis A or Hepatitis B_____ Other: ______________________

Allergies:

Operations/Serious Injuries:

Description of any other current health conditions requiring medication, treatment, or special restrictions/considerations while at the retreat:
____

____

Medications

Medication: ________________________ Dosage: _____________________ Time: ________________
Medication: ________________________ Dosage: _____________________ Time: ________________
Medication: ________________________ Dosage: _____________________ Time: ________________
Medication: ________________________ Dosage: _____________________ Time: ________________

Keep medication in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration. All medications, including over-the-counter/non prescription, must be turned into the camp nurse at registration.

Are all required school immunizations up to date? Yes ___ No ___ Date of last booster: ______________

Insurance Information

Insurance Company: _________________________________ Policy Holder: ________________________
Policy #: ____

Health Exam

I certify that the information provided is correct and complete so far as I (the undersigned) know, and the person herein described as the student has permission to engage in all prescribed retreat activities, on or off Camp Kirkwood premises, except as noted on this health form. I understand that it is the responsibility of the parent/guardian to inform iMPACT RETREAT of any changes of additions to this form on the day the child arrives to the retreat. I also certify that the above-named student has received a health exam from licensed medical personnel within the past 24 months of the time the student will be at the iMPACT Retreat. I have listed any physical condition requiring restrictions on participation in the retreat program and description of such restrictions. I have also listed any current or ongoing treatments or medications.

Date of Last Health Exam: ________________________ Today's Date: ________________________
Signature: ___________________________________ Print Name: ______________________________

Restrictions

Are there any physical restriction for participation: YES / NO

If YES, Please explain:
____
____

EMERGENCY MEDICAL TREATMENT AUTHORIZATION

Purpose: To enable a custodial parent or guardian to authorize emergency medical treatment to his or her child **if** the child becomes seriously ill or injured while participating in the iMPACT Camp Program and the custodial parent or guardian **cannot be contacted**.

DIRECTIONS AND CONSENT

1. If my child seems to need emergency medical treatment, **I direct** that my child be transported to a nearby hospital.

2. If, after arranging for my child's transportation to a nearby hospital, reasonable efforts to contact me are unsuccessful, **I then direct** that reasonable efforts be made to contact at least one of the medical care providers listed below.

3. If neither I nor either of the medical care providers listed below can be successfully contacted to discuss emergency medical treatment for my child, **I consent** to any emergency medical treatment considered necessary by the medical care personnel treating my child. This consent to emergency medical treatment **does <u>not</u> authorize** surgery **<u>unless</u>** before the surgery, two physicians agree that surgery is necessary (one of whom **must be** one of the medical care providers named below – but only if available).

Medical care providers:

Physician – General ____Phone (   ) _______________

Physician - Specialist ____ Phone (   ) _______________

Additional information:

____

____

Date ________________ Signature of Parent/Legal Guardian ____

FACTS ABOUT MY CHILD MEDICAL HISTORY

1. Does your child have any physical disabilities? Yes [ ] No [ ] If yes, please describe below.

____

____

2. Is your child currently taking any medications? Yes [ ] No [ ] If yes, please list below.

____

____

3. Does your child have any dietary allergies or restrictions? Yes [ ] No [ ] If yes, please list below.

____

____

City Gospel Mission Teen Impact - iMPACT RETREAT 2019

PARTICIPATION CONSENT, WAIVER, AND RELEASE

I, _______________________________________, give my child ______________________________________
(Parent/Legal guardian's name) (Child's name)

permission to participate in the iMPACT Retreat 2019 program (the "**Program**"). By signing this Participation Consent, Waiver and Release (this "**Consent**"), I am documenting that: 1) I understand and agree to each of the statements in this Consent, and 2) I agree, for myself and my child, to hold City Gospel Mission and its partners (including without limitation North Presbyterian Church (Northside), Israel Baptist Church (Hamilton), La Viña Cincinnati (Price Hill), River of Life Church (OTR), Winton Community Free Methodist Church (Spring Grove Village) , ______________________________ (Name of sending church if not on the list), agents, employees, representatives, successors, and assigns (collectively "**CGM**") harmless of and from any and all liability of whatever nature which may arise out of or result from my child's participation in the Program.

- **Emergency Medical Treatment**: If my child becomes seriously ill or injured while participating in the Program, including but not limited to during transportation to or from the Program, any authorized member of CGM may seek and obtain emergency medical treatment for my child as he or she deems necessary.

- **Faith-based activities**: I acknowledge that the Program is an initiative of City Gospel Mission, which is a Christian, faith-based organization. My child has permission to participate in faith-based activities that may be offered during the Program.

- **Publicity**: CGM may use my child's name and/or photograph(s)/video(s) for the purposes of duplication, publicity and/or publication.

- **Risk of Injury**: From time to time, children in the Program may participate in sports and other physical activities that carry an inherent risk of injury. My child has permission to participate in all Program activities and, on behalf of my child, I fully assume the risk of injury associated with such participation. If my child has, or is suspected to have, any medical conditions that might increase his or her risk of injury or illness, I have notified CGM of such medical conditions on the Emergency Medical Treatment Authorization form. I also acknowledge full legal and financial responsibility for (i) any injuries incurred by my child in connection with the Program, and (ii) any liability to others which may result from my child's actions in connection with the Program.

- **Transportation**: The authorized members of CGM may secure and/or provide travel for my child to and from the Program and any and all activities related to the Program.

- **Data Collection:** The authorized members of CGM may collect information to use for future funding of the PB Ministry and the stewardship of current funding.

Acknowledgement of Understanding: I have read this Consent, I understand the terms used in it, and I have willingly signed it as evidence of my acceptance of all the conditions stated in it. I understand that, in return for CGM's acceptance of my child into the Program, I am giving up, for myself and my child, and for my own and my child's heirs, executors, and administrators, any right to legal recourse against CGM for negligent conduct (but not for reckless or intentional conduct). In the event that anyone brings a claim against CGM for which I have released CGM in this Consent, I shall personally indemnify CGM against all of its losses and damages, including reasonable attorney's fees.

I understand that, unless and until I notify CGM in writing that I wish to retract this Consent (at which time my child's participation in the Program will end), this Consent shall apply each and every time, and remain in effect for as long as, my child participates in any Program activities.

Because I am signing this Consent on behalf of a minor, I certify that I am my child's custodial parent or legal guardian with full authority to act on my child's behalf with respect to everything addressed in this Consent.

____ ________________________________

Signature of Parent/Legal guardian Date

iMPACT PACKING LIST

Send only sturdy play clothing, old towels, sleeping bags, etc. NO NEED TO BUY NEW! Please mark each article of clothing with a tag or marking pen! Use first and last name. A sleeping bag is much easier than sheets and blankets, although bringing an extra “sheet” is a good idea for heat. Use the suggested list below and go over it carefully with your student so he/she has a part in packing. Pack accordingly for 2 Days and 2 Nights.

Please, NO SUITCASES! Please put all clothing and sleeping materials in a large garbage bag and all of your toiletries and heat sensitive items in a separate ziplock baggie. Please put your name on both bags.

Packing SUGGESTIONS

_____ Sleeping bag or two sheets and blankets
_____ Pillow
_____ T-shirt (No Tank-tops/ Spaghetti strap tops)
_____ Sweatshirt
_____ One pairs of long pants
_____ Comb/brush
_____ Socks (plenty)
_____ Underwear (plenty)
_____ 1 pair of tennis shoes
_____ Raincoat
_____ Pajamas
_____ Toothpaste/Toothbrush
_____ Soap
_____ Towels (shower)
_____ Prescription Medications (orig. containers)
_____ Washcloth
_____ Toiletries
_____ Jacket
_____ Notebook and Pen
_____ Bible

<u>We suggest that you do not bring cell phones,</u> but they are allowed with parent permission. Cell phones are not to be used during activities and sessions. They are only to be used in the cabins for a limited time each morning/night. If a cell phone is lost or stolen, it is not the responsibility of the camp or the retreat leaders.

PARENT INFORMATION AND CONTACT SHEET

iMPACT Retreat –November 1-3, 2019

City Gospel Mission

iMPACT Retreat Pastor:

Joe Dixon

City Gospel Mission WK Unplugged Director

513-226-3556

jdixon@citygospelmission.org

Retreat Information and Student Contact:

Trisha Wagner

Director of Hispanic Outreach

513-295-7914

twagner@citygospelmission.org

Camp Kirkwood:

Kirkwood Camp & Conference Center

5719 St. Rt. 73 West

Wilmington, OH 45177

Office (937) 382-3535

Email: info@campkirkwood.net

Web site: www.CampKirkwood.net