

2017 KCLYC Senior High Mission Trip

Registration & Health Information Form

Trip Dates July 10th – 17th, 2017

\$100 Non-Refundable Deposit Due With Registration
\$550 Full Trip Cost is Non-Refundable after May 1st, 2017

Participant Information

Participant Name _____ Date of Birth _____
Home Address _____ City _____
State _____ Zip _____ Home Phone _____ Student Cell Phone _____
Parent/Guardian(s) _____ Cell Phone _____
Parent/Guardian Email(s) _____
Emergency Contact _____ Emergency Phone _____
School _____ Grade (2016-17) _____ Church _____
I request to be in a group with (1 person) _____ T-Shirt/Hoodie Size (adult sizing) _____

Parent/Guardian Consent

I hereby give permission for _____ to participate in all activities, work projects, and programs during the 2017 KCLYC Senior High Summer Mission Trip.

I understand that all measures will be taken to contact me in the event of a medical emergency involving my son or daughter. If I cannot be reached I give the adult leadership authority to make medical decisions in the best interest of my son or daughter.

Parent/Guardian Signature _____ **Date** _____

Participant Commitment

I _____ agree to represent myself in a positive and respectful manner throughout the 2017 KCLYC Senior High Summer Mission Trip. I will listen to and follow the directions of all adult leaders and sponsors supporting me on this trip. If I choose not to follow the rules I am choosing to be unsafe and may be sent home at my parents/own expense.

Student Signature _____ **Date** _____

- ⇒ Please return your registration form and deposit to: **Your Church Youth Leader** or **Office**
- ⇒ Please make all checks out to: **Your Congregation (Memo Line- 2017 KCLYC Mission Trip)**
- ⇒ **Questions?** Contact your youth leader or pastor

(Please complete the Health Information Form on the back side of this registration ➡)

Health Information Form

Participant Name _____

Insurance Policy Holder _____

Birthdate of Policy Holder _____

Employer _____

Insurance Co. _____ Group # _____

Insurance Co. Address _____

Insurance Co. Phone _____ Policy/ID# _____

Family Doctor/Phone _____

Immunizations Up To Date : Yes No My Child Is Not Immunized

Conditions: Asthma Epilepsy Diabetes Heart Conditions Behavioral
 Other **Explain:** _____

Allergies: Insect Stings Poison Ivy Seasonal Drug Food
 Other **Explain:** _____

Medications:

This person takes **NO** medications.

This person takes the following medications: _____

(medications must be in their prescribed container including current medication information)

Copy of Insurance Card
FRONT SIDE

Copy of Insurance Card
Back SIDE