

## FPCA Mission Retreat Registration & Medical/Liability Release Form

Participant Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ SSN: \_\_\_\_-\_\_\_\_-\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_ T-Shirt Size: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Relationship to Participant: \_\_\_\_\_

Preferred Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

Preferred Dentist: \_\_\_\_\_ Phone: \_\_\_\_\_

Preferred Hospital: \_\_\_\_\_ Phone: \_\_\_\_\_

### Health History

Allergies and other conditions: (please check all that apply)

<input type="checkbox"/> Insect Allergies	<input type="checkbox"/> Drug Allergies	<input type="checkbox"/> Other Allergies
<input type="checkbox"/> Frequent colds	<input type="checkbox"/> Heart	<input type="checkbox"/> Asthma
<input type="checkbox"/> Physical Handicap	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Hay Fever
<input type="checkbox"/> Frequent Stomach Upsets	<input type="checkbox"/> Diabetes	

If you checked any of the above, please give details (i.e., include normal treatment of allergic reactions): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Participant Name: \_\_\_\_\_

Date of last tetanus shot: \_\_\_\_\_

Name and dosage of any routine medications: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Swimming restrictions: \_\_\_\_ No \_\_\_\_ Yes, Explain \_\_\_\_\_

Activity restrictions: \_\_\_\_ No \_\_\_\_ Yes, Explain \_\_\_\_\_

*If you have medical insurance, your carrier will be billed for medical charges in case of illness or injury on a mission retreat.*

Do you have health insurance? \_\_\_\_ No \_\_\_\_ Yes (*If yes, please complete information below*)

Carrier: \_\_\_\_\_ Policy #: \_\_\_\_\_

Carrier Address: \_\_\_\_\_

Carrier phone number: \_\_\_\_\_

Policyholder's name and SSN: \_\_\_\_\_

*Please attach a copy of your medical insurance card*

*All information is kept confidential and is used for the sole purpose of providing a safe environment for the student participants at First Presbyterian Church of Aiken.*

Participant Name: \_\_\_\_\_

**Permission and Release of Liability:**

Every activity sponsored by this Church is carefully planned and adequately supervised by mature adults. However, even with the best of planning and precaution, unforeseen events can occur. The participant understands that they are signing for both medical and liability release *Please read the following carefully:*

*I certify that I am physically fit to participate in all mission-trip activities, except as noted in this document, and have no communicable diseases apparent at this time. In the event that I am unable to communicate and the emergency contact cannot be reached, I hereby grant permission to the adult sponsors and leaders to secure proper medial treatment. I realize that, if necessary, the treatment may include an injection, anesthesia, or surgery. I agree to assume and accept all risks and hazards inherent in this type of church-related activities and agree not to hold this Church, its employees, or volunteer assistants liable for damages, losses or injuries to the person or property undersigned.*

\_\_\_\_\_  
Participant Signature

\_\_\_\_\_  
Date

As a participant on a Mission Retreat, remember that you are representing Christ as well as First Presbyterian Church. On any trip sponsored by First Presbyterian Church-Aiken, drugs, alcohol, and/or any tobacco products will not be permitted. In the event that any participant is found in possession or under the influence of any of the above, the participant will be sent home at their expense.

*I, the undersigned, agree to comply with all of the rules and policies stated by First Presbyterian Church and understand the penalties for any violation committed*

\_\_\_\_\_  
Participant Signature

\_\_\_\_\_  
Date