



DISCIPLE NOW

Complete all fields and print in blue or black ink. Completed applications should be turned in to the Ben or the front office along with a \$50 deposit (or full amount) made payable to "New Hope Presbyterian Church." Full cost for the retreat is \$120.

GENERAL INFORMATION & MEDICAL RELEASE FORM

First & Last Name _____

Age: _____ Birthdate: _____ Grade: _____ Gender: _____

Mailing Address: _____

E-mail address: _____

Parent Phone number(s): _____

Adult T-shirt Size: ____XS ____S ____M ____L ____XL ____XXL ____XXXL

Emergency Contact:

Name: _____ Relationship to you: _____

Mailing Address: _____

Phone numbers: (home) _____ (work) _____ (mobile) _____

Please submit deposit (or full amount) and forms signed by parent by Friday, March 15th to either Ben Bethea or the New Hope office.

Would you like this permission form to serve as a release for all New Hope Student Ministry activities your child attends between the time of submission and September 1, 2019?

Yes No



Please note: I will be taking photos/video of the group to use in a video of the weekend. This may be shared on the church website, student Instagram & Facebook pages, or in other publications such as a trip video. If you object to the use of your child's photos or video, please inform the church office.

I, the undersigned parent/legal guardian, hereby give permission for _____ to participate in the Disciple Now event sponsored by the Chapel Hill Presbyterian Church Student Ministry, happening April 13th - 14th, 2018. I affirm that the above-named minor has no health problem(s) that would preclude their participation in these activities. Further, I expressly agree to hold harmless New Hope Presbyterian Church, its employees and agents, for any injury to the minor or damage to their personal property that may be incurred by or as a result of their participation. In case of a medical emergency, I understand every reasonable effort will be made to contact me. In the event that I cannot be reached through reasonable efforts, I hereby give my permission to the physician selected by the leader in charge to secure proper treatment or to hospitalize, to order injections, anesthesia, or surgery for my child.

-Primary Physician

(Indicate name, phone #)

-Medical Insurance:

(Indicate company name, ID #)

-My child has the following allergies and/or medical concerns:

(Indicate any special care needed)

-My child is currently taking the following medication(s):

(Indicate over-the-counter or prescription, frequency, dosage)

Printed Name of Parent/Legal Guardian

(Date)_____

Signature of Parent/Legal Guardian

(Date)_____

