

M4 Camps 2026

PARENTAL CONSENT AND MEDICAL INFORMATION FORM Photo & Video Release

Participant's First Name _____ Middle _____ Last Name _____

Address _____ City _____ Zip _____

Home Phone () _____ Birthdate ____/____/____

MEDICAL INFORMATION:

Does your child have an allergic reaction to bee stings, bites, etc.? _____

To any medicines? _____ If yes, which ones _____

Is there any medical information you feel we should have concerning your child?

ALL MEDICINE MUST BE TURNED OVER TO THE CHURCH CHAPERONES BEFORE LEAVING!
EMERGENCY NUMBERS:

Doctor's Name _____ Phone () _____

Parent/Guardian's Name _____ Cell Phone () _____

Other Phone () _____

Place of Work _____ Phone () _____

Insurance Carrier _____ ID # _____

Address _____ City _____ St _____ Zip _____

Phone () _____ Other numbers/info _____

M4 Ventures, LLC & Camps, & Waukaway Springs Christian Retreat Center are Christian organizations, and Christian standards of conduct, dress, and attitude are expected from each participant. I GIVE MY CONSENT FOR MY SON/DAUGHTER TO PARTICIPATE IN M4 Kids' Camp. When it is deemed necessary for my son/daughter's health, the leaders may have my son/daughter hospitalized or use outside medical, surgical, or dental aid, in which case all such expenses shall be paid for by me. I understand that by attending, we as participants are assuming all risks related to any communicable disease. I shall in no way hold M4 Ventures, Waukaway Springs Christian Retreat Center, or its representatives responsible for any financial obligation. I understand that as a participant, my child may be photographed or videotaped during normal camp or event activities and these photos/videos may be used in promotional materials.

Parent/Guardian _____ Date ____/____/____