

twelve30 YOUTH WEEKEND '10

It's that time of year again... time for our annual spring retreat. What we here at CFC affectionately call YOUTH WEEKEND. We will most likely once again be heading off campus so we will need a Medical Release Form completely filled out and signed by your parents/guardians in order for you to go with us. Now, you know that where we will be going is a surprise, so don't even ask. But if your parents would like to know just have them get a hold of me and I will tell them all about it.—and then swear them to secrecy! ☺

We will kick things off at 7:00pm Friday night. And then we thought it'd be fun for you to stay the night at each other's homes Friday night. We are recommending that you get a group of your friends together and have a sleep over. (Now, c'mon guys, you know you secretly have wanted to have a sleep over with your buddies for a long time now. And here's your excuse!) You will need to be back at CFC **no later than 9:30am**, Saturday. We should be wrapped up at approximately 10:00pm that night.

The registration fee includes lunch and dinner Saturday, transportation to our "event", and a T-shirt...and no, not another long-sleeve white T-shirt!

Be sure you have completely filled in all information on the [Registration Form](#), have a [signed](#) and completed [Medical Release Form](#), and your [payment of \\$35.00](#).



REGISTRATION FORM

Name _____ Age _____

Phone number _____ Grade _____

Address _____

Home Church _____

Emergency contact _____

Relationship to registrant _____

Phone number _____ Alternate Number _____

Medical Release Form attached _____ \$35.00 Registration Fee, attached _____

Shirt Size: X-Large _____ Large _____ Medium _____ Small _____



MEDICAL RELEASE FORM
CHRISTIAN FELLOWSHIP YOUTH GROUP

I, _____ (Mother____ Father ____ Legal Guardian____)
am presenting my child _____(Son____ Daughter____) who is
_____ years of age; hereby voluntarily consent to the rendering of such care, including diagnostic procedures,
surgical and medical treatment, and blood transfusions, by authorized members of the hospital staff or their
designees, as may in their professional judgment deem necessary.

I hereby acknowledge that no guarantees have been made to me as to the effect of such examinations or treatment
on child's condition. I have read this form and I certify that I understand its contents.

We/I hereby give my consent to _____ Marc Galaske/ Christian Fellowship Church _____ who will be caring for
our (my) child for the period _____ March 19, 2010 _____ through _____ March 20, 2010 _____ to arrange for routine or
emergency medical/surgical/dental care and treatment necessary to preserve the health of our (my) child.

We/I acknowledge that we are (I am) responsible for all reasonable charges in connection with care and
treatment rendered during this period:

Name _____ Family Physician _____
(Mother/Father/Legal Guardian)

Address _____ Pediatrician _____
_____ Surgeon _____

Telephone No. _____ Orthopedist _____

Name of Health Insurance Carrier: _____ Child's Allergies, if any: _____

_____ Date of last tetanus booster _____

Group No. _____ Medicines Child is taking _____

Agreement No. _____

Signature: _____ Date
(Mother/Father/Legal Guardian)

Witness: _____ Date

In case of emergency I can be reached at _____