

**First Church of Lombard  
United Church of Christ  
2<sup>ND</sup> YEAR CONFIRMATION FALL RETREAT  
Friday, September 16 – Sunday, September 18, 2011  
Tower Hill Camp and Retreat Center**

**Registration and Release**

Name of Participant \_\_\_\_\_

Address \_\_\_\_\_ E-Mail \_\_\_\_\_

Telephone \_\_\_\_\_ Cost to Participant   \$45  

The undersigned parent/guardian of the participant named above gives permission for that participant to travel to the 2<sup>nd</sup> Year Confirmation Fall Retreat at Tower Hill Camp and Retreat Center in Sawyer, Michigan from Friday, September 16, 2011 – Sunday, September 18, 2011, and assumes all responsibility for any injuries to that participant and any loss or damage of property that may occur. The undersigned also indemnifies and holds harmless First Church of Lombard, United Church of Christ, Tower Hill Camp and Retreat Center, the Illinois Conference of the United Church of Christ, the United Church of Christ, and any and all leaders supervising such activity, against any and all direct or indirect claims and damages whatsoever in connection with this outing. Further, the undersigned grants permission to Rev. Robert Hatfield to obtain any needed medical treatment for this participant.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

*All Participants must have a current Emergency Medical Information Form on file at First Church. If you haven't filled one out yet, copies are available in the church office or can be downloaded from our website.*

**Emergency Medical Information Form  
First Church of Lombard, UCC**

*Parents: Please fill out this information form for each minor child who is participating in First Church of Lombard activities. This form is valid for 12 months from the date signed. Please make sure to fill out a new form if your insurance changes. All forms will be stored in a secure area and will be shared with activity leaders as needed.*

Student's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Parent/Guardian Name(s) \_\_\_\_\_

Home Address (include city, state & zip) \_\_\_\_\_

Home phone \_\_\_\_\_ Cell phone \_\_\_\_\_

Emergency contacts (in case parent/guardian cannot be reached)

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home phone \_\_\_\_\_ Cell phone \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home phone \_\_\_\_\_ Cell phone \_\_\_\_\_

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List information on allergies, medication and physical limitations (attach separate sheet if necessary):

\_\_\_\_\_  
\_\_\_\_\_

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Physician Name \_\_\_\_\_ Physician Phone \_\_\_\_\_

Physician Address (include city, state, & zip) \_\_\_\_\_

Affiliated Hospital(s) \_\_\_\_\_

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Insurance Information (you may attach a copy of the front and back of your insurance card to this form):

Insurance Company \_\_\_\_\_ Insurance Phone \_\_\_\_\_

Account/Policy/ID # \_\_\_\_\_

Name of covered client \_\_\_\_\_

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In the event that I, or the other emergency contacts cannot be reached in an emergency, I give my consent for First Church of Lombard, UCC, to arrange for emergency medical/dental care and treatment necessary to preserve the health of my child. I authorize the rendering of such care, by members of the hospital staff, as deemed necessary in their professional judgment.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_