Youth Mission Trip

2019 REGISTRATION

Cost is $700 with a $200 down payment to secure spot - maximum amount: 50 students

Parent Info

Parent/Guardian Name(s): ________________________________

Home Phone: ________________________________

Work Phone: ________________________________

Cell Phone: ________________________________

Cell phone carrier________________ *(this allows for text messaging)*

Youth Info

First & last name: ________________________________

Youth email: ________________________________

Cell Phone: ________________________________

Youth cell phone carrier: ________________________ *(allows for text messaging)*

Age: ________

Year in school:________

Name of school:________________________________

CONTINUE ON BACK PAGE

Office use

$200 downpayment date__________ type____________ amount________balance due________

Other payments: Date____________ type____________ amount________balance due________

Date____________ type____________ amount________balance due________

FINAL payment: Date____________ type____________ amount________balance due________

Boston Mission Trip Medical Waiver 2019 WAIVER

This form will be kept on file for the duration of the Summer Youth Trip to the Boston, from July 21 - July 27, 2019

I, the Parent/Guardian of ________________________________ (youth name)
Youth DOB ______________________ 2019–2020 School Grade ______________,

hereby give my approval for his/her participation in any and all activities of Fox Point Lutheran Church during the Summer Youth Trip to Boston, July 21-27, 2019. I assume all risks and hazards incidental to such participation, including transportation to and from activities. I do hereby waive, release, absolve, and indemnify the church, its servants, and participants, as well as transporting the above named youth to and from related activities, for any injury or action resulting in a medical claim. I also give the physician/hospital selected by the program supervisor permission to secure proper treatment for my child, should it become necessary. I also assume responsibility of all medical expenses incurred. Should it be necessary for my child to return home due to medical reasons or otherwise, the undersigned shall assume all transportation costs.

Parent/Guardian Name(s): ____

Cell Phone: ________________________________ belongs to:_________________(name)

Cell Phone: ________________________________ belongs to:_________________(name)

Address: ____

____

Emergency Contact Person (other than parent/guardian):

____

Phone: __________________________Relation to Child: ___________________________

Insurance Company: ____

Policy Number: __________________

Insurance ID Number: ___________________________

Physician's Name: ________________________Phone Number: ________

Known Allergies including food allergies:

____

Special Medical Conditions/Concerns: ____

Medications (instructions/dosages): ____

Date of last tetanus shot: _______________________

Parent/Guardian Signature: _______________________________________ Date: ___________