

2021 RCM 56 Kids! Ministry Registration Form

Registration Fee - \$35

Child's Name

Date of Birth

[] Male [] Female

Address

Youth Cell Phone Number

Grade **Completed**

City

State

Zip Code

parent email (please print clearly)

Home Church

Youth Ministry (if other than home church)

Parental Release I give permission for my child, _____, to participate
Child's Name
in the Youth activities of Rawlinsville Camp Meeting.

- I give permission for the Rawlinsville Camp Meeting Staff to transport my child to and from any offsite activities in a manner which the staff of Rawlinsville Camp Meeting deems appropriate.
- I give Rawlinsville Camp Meeting staff permission to photograph, videotape, record, and interview my child during the camp session for the purpose of evaluation, promotion, or advertisement of the camp ministry. This is including, but not limited to, videos, newsletters, displays, and internet web sites.
- I state that I am responsible for the care and supervision of the above named child while they are attending Rawlinsville Camp Meeting. If I am unable to attend Rawlinsville Camp Meeting, I declare that _____ in cabin # _____ will be in attendance at Rawlinsville Camp Meeting during the hours that my child is attending RCM and will be responsible for the care and supervision of my child.
- I hereby release Rawlinsville Camp Meeting, its staff, and sponsoring churches from responsibility and liability for any injury or illness that my child may sustain during the activities of Rawlinsville Camp Meeting. I expect to be contacted as soon as possible in the event of an injury or illness requiring medical treatment. In the event of an emergency, I authorize an RCM staff member, as an agent for me, to consent to any medical, dental, surgical procedures deemed necessary by a licensed professional for the diagnosis, treatment and/or care of my injured or ill child.

Parent Signature

Date

Day/Evening Contact Number

Parent Name

Parent Cell/Primary Number

Backup Contact Name

Backup contact number

Medical Information

Family Physician _____ Phone Number _____
Allergies _____
Medications _____
Physical Limitations or other medical conditions _____