

The Episcopal Center for Renewal

Diocese of Dallas and Ft. Worth

Adult

New Beginnings Registration and Medical Release Form

Please print and leave no spaces blank. PLEASE NOTE: This form must be completed, the Community Contract and Guidelines (opposite side of this page) signed, the Sponsor/Adult Leader Registration Form and the \$65.00 fee before the weekend.

(Please Print):

Name: _____ Name on _____
(Last) _____ (First) _____ Nametag _____

Street Address _____ Sex: (Circle one) M F

City _____ State _____ Zip Code _____ Birthday ____/____/____

Phone # (____) _____ Cell # (____) _____ Sponsor ____ Team ____ (check one)

Your Church _____ City _____

E-mail _____ T-shirt size (circle one) S M L XL XXL XXXL

HEALTH AND INSURANCE INFORMATION: *In case of emergency, please notify*

Last Name _____ First Name _____ Relationship _____

Address if different from above: _____

Home # (____) _____ Cell # (____) _____ Pager # (____) _____

Family Dr. Name _____ Phone # (____) _____

Insurance Carrier _____ ID or Group # _____

Name of Primary Insured _____

Allergies: Food, Drug, or Environmental _____

Please list all medications taken regularly, any dietary restrictions or physical limitations: _____

Do you have any other known medical conditions we should be aware of (such as asthma, diabetes, low blood sugar, seizures, etc)?

Yes ____ No ____ If yes, explain _____

In case of illness or accident, I give permission to be evaluated and treated by available medical personnel. I also understand that no obligation or responsibility in regard to rendering treatment or medication is assumed or undertaken as a consequence of this activity; notwithstanding, the adults in charge have permission to authorize any medical care, which in their judgment, they deem necessary and to sign any medical forms necessary on my behalf and I do hereby release The Episcopal Center for Renewal, Episcopal Dioceses of Dallas and Ft. Worth, my parish and all persons connected therewith from any liability, claim and expense related to any such condition, circumstance or treatment.

Signature _____ Date _____

*(Please remember to read and sign the Community Covenant on the opposite side of this page before returning.)
Mail application & fees to: The Episcopal Center for Renewal, 10290 Monroe Drive, Suite 101, Dallas TX 75229*

OFFICE USE ONLY: Fee Paid ____ cash/check/credit card ____ Date Received ____ Acceptance ____