

**The Episcopal Center for Renewal**  
10290 Monroe Drive Suite 101, Dallas TX 75229-5718  
*Dioceses of Dallas and Ft. Worth*  
**New Beginnings Registration and Medical Release Form**

Deadline: 10 days  
Prior To Event  
**NO REFUNDS**

*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 and the \$65.00 fee paid before youth can participate in New Beginnings.*

**PARTICIPANT INFORMATION (Please Print):**

Name: \_\_\_\_\_ Name on \_\_\_\_\_  
(Last) \_\_\_\_\_ (First) \_\_\_\_\_ Nametag \_\_\_\_\_  
Street Address \_\_\_\_\_ Sex: (Circle one) M F  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Birthday \_\_\_\_/\_\_\_\_/\_\_\_\_  
Phone # (\_\_\_\_) \_\_\_\_\_ Grade \_\_\_\_\_ Age Now \_\_\_\_\_ Participant \_\_\_ Sponsor \_\_\_ Team \_\_\_ (check one)  
Your Church \_\_\_\_\_ City \_\_\_\_\_  
(If you are coming with a friend, what church group will you be with: \_\_\_\_\_)  
E-mail \_\_\_\_\_ T-shirt size (circle one) S M L XL XXL XXXL

**CLERGY**

**YOUTH LEADER (if applicable)**

*Clergy Signature* \_\_\_\_\_ *Youth Leader Signature* \_\_\_\_\_

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

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address if different from above: \_\_\_\_\_

Home # (\_\_\_\_) \_\_\_\_\_ Mobile # (\_\_\_\_) \_\_\_\_\_ Pager # (\_\_\_\_) \_\_\_\_\_

Family Dr. Name \_\_\_\_\_ Phone # (\_\_\_\_) \_\_\_\_\_

Insurance Carrier \_\_\_\_\_ ID or Group # \_\_\_\_\_

Name of Primary Insured \_\_\_\_\_

Allergies: Food, Drug, or Environmental \_\_\_\_\_

Does your child have any other known medical conditions we should be aware of (such as asthma, diabetes, low blood sugar, seizures, etc.? Yes No If yes, please explain \_\_\_\_\_

Do you give permission for us to give your child Tylenol or Advil, if needed? Yes No

List all medications, which you authorize us to give your child including the name, dose, and time to be taken:  
\_\_\_\_\_  
\_\_\_\_\_

Please list any dietary or physical restrictions: \_\_\_\_\_

I give permission for my child to attend New Beginnings. In case of illness or accident, I give permission to have my child evaluated and treated by available medical personnel. I understand a reasonable attempt will be made to notify me in such an event. 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 child's 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.

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

*(Please remember to read and sign the Community Covenant on the opposite side of this page before returning.)*

**OFFICE USE ONLY:** Fee Paid \_\_\_\_\_ cash/check/credit card \_\_\_\_\_ Date Received \_\_\_\_\_ Acceptance \_\_\_\_\_