

# Men's Retreat Registration Form

Name: First \_\_\_\_\_ Last \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: (\_\_\_\_\_) \_\_\_\_\_ E-mail: \_\_\_\_\_

Church Name: \_\_\_\_\_ City of Church \_\_\_\_\_

**Yes**, if all the beds are taken, I am willing to be on the waiting list. I understand that I will get a call from Keith to let me know that I am on the waiting list. I also understand that this means I will need to bring an air mattress or sleeping bag pad to camp in case a bed does not open up.

Please let us know if you have any special needs or requests: \_\_\_\_\_

Are you in leadership?  Yes  No If yes, what area (i.e., pastor, elder, small group leader, etc): \_\_\_\_\_

**The cost for registration is \$110.00 per person,  
\$99.00 per person if mailed by Jan. 15th, 2011,  
or \$99.00 per person if 5 or more registrations are mailed together by Feb. 15th, 2011**

**Make checks payable to CMA Men's Ministry and send it along with  
the completed form(s) to: **931 - 127th Ave NE, Blaine, MN 55434****

To cancel contact John Wilson (763-862-0454 or jwilson.online@gmail.com) by February 15th, 2010 to receive a full refund. After that date there will be no refunds.

## RETREAT EMERGENCY CONTACT / MEDICAL INFO

emergency contact name:		M	F
emergency contact phone #:			
health insurance company:			
insurance ID #:		group #:	
physician's name:		phone #:	

**HEALTH HISTORY - CHECK (X) THOSE THAT APPLY**

- CHICKEN POX
- ASTHMA
- CONVULSIONS
- DIABETES
- EAR TROUBLE
- EMOTIONAL PROBLEMS
- EPILEPSY
- SKIN PROBLEM
- HEART TROUBLE

- ALLERGIC TO:**
- PENICILLIN
  - INSECT STINGS
  - OTHER(LIST):

**IMPORTANT**

I UNDERSTAND THAT EVERY EFFORT WILL BE MADE TO PROTECT AND SAFEGUARD ALL GUESTS. I AGREE NOT TO HOLD BIG SANDY CAMP LIABLE FOR ANY ILLNESS OR MISHAP FROM ANY CAUSE WHATSOEVER.

BIG SANDY CAMP MAY USE COMMENTS, PHOTOS, OR VIDEO, INCLUDING COMMENTS, IN ITS PROMOTIONAL MATERIALS.

IN THE CASE OF EMERGENCY, IF I CANNOT BE CONTACTED, OR THE EMERGENCY NUMBER CANNOT BE CONTACTED, I HEREBY GIVE PERMISSION TO THE PHYSICIAN SELECTED BY THE CAMP DIRECTOR TO HOSPITALIZE, SECURE TREATMENT FOR AND TO ORDER INJECTION, ANESTHESIA OR SURGERY FOR MYSELF, AS NAMED ABOVE.

**IMMUNIZATION RECORD**

DATE OF LAST TETANUS BOOSTER: \_\_\_\_\_

LIST ANY ACTIVITY RESTRICTIONS AND/OR MEDICATION THAT YOU ARE ON: (attach additional sheets if necessary)

ALL ABOVE INFORMATION IS CORRECT AS LISTED.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_