2021 ELMS REGISTRATION FORM

Last Name: _____ First Name: _____

Address: _____ City: _____ State: ___ Zip: _____

Age: _____ (*as of Summit date*) Birth Date: ___/___/_____ Gender: [ ] Male [ ] Female

Email Address: _____

Parent or Guardian Name: _____

Parent or Guardian Cell Phone: (___) ____ - _____ Work Phone: (___) ____ - _____

Home Church & Pastor _____/_____

Youth Pastor/Leader: _____ Cell: (___) ____ - _____

Emergency Contact Person (other than persons listed above) _____

Phone: (___) ____ - _____ Relationship to Student: _____

Person who will be picking up student: _____ Phone: (___) ____ - _____

STUDENT BEHAVIORAL AGREEMENT

I AGREE TO FOLLOW AND COMPLY WITH ALL SUMMIT RULES, INCLUDING BUT NOT LIMITED TO, DRESS CODE, AND COOPERATE WITH SUMMIT STAFF AT ALL TIMES.

Student's Signature: _____ Date: _____

Signature of Parent/Guardian: _____ Date: _____

ACTIVITY PARTICIPATION PERMISSION

The undersigned hereby forever releases and discharges TMCC and New Horizons Ministries of any and all liability of any nature which may arise while _____ is a camper as set forth above. Undersigned further agrees to never sue or file a claim against aforesaid TMCC or New Horizons Ministries Conference for any injury which may occur to undersigned while undersigned is involved with any activities of or related to TMCC or New Horizons Ministries Conference.

PARENT SIGNATURE REQUIRED: _____ **DATE:** _____

SUMMIT T-SHIRT (PLEASE CIRCLE SIZE CHOICE) - $15

A-SM A-Med A-Lg A-xL A-2xL A-3xL

COST: $35

SUMMIT PHOTOGRAPHY/VIDEOGRAPHY (CHECK IF APPLIES)

_____ I **DO NOT** want this student's image/likeness to be used in TMCC & NHM publications.

(continued on back)

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AUTHORIZATION FOR MEDICAL CARE OF A MINOR

In my absence, I _____ hereby authorize the FOUR:12 Director or designated representative to obtain medical treatment which may be deemed necessary for _____. Furthermore, I authorize the proper dispensing of _____'s prescription drugs (if applicable) as listed on this application. I also hereby authorize any physician called upon by the FOUR:12 Director or designated representative to render medical treatment that, in their judgement, may be deemed necessary for the well being of _____.

Signature Required: _____ Date: _____
(Signature of Parent/Guardian)

TREATMENT INFORMATION

Minor's Date of Birth: ___/___/_____ Date of Tetanus Shot: ___/___/_____
Minor's Doctor's Name & Phone: _____
Minor's Medical History: _____
Insurance Company and/or Government Program: _____
Address: _____
Phone: (___) ____ - _____
Subscriber ID or Contract Number: _____
Admission Pre-certification Phone: (___) ____ - _____
Group Name (Employer): _____
Group Number: _____
Employer Address:_____
City: _____ State: _____ Zip:_____

PLEASE LIST CURRENT PRESCRIPTION DRUG(S)

_____
_____
_____

LIST ANY ALLERGIES/MEDICAL CONDITIONS/DISABILITIES

_____
_____
_____

INSURANCE AUTHORIZATION

I authorize the release of any medical information necessary to process a claim for the dependent in this Summit application. I authorize payment of medical benefits to the physician or supplier of services rendered to my dependent.

Signature Required: _____ Date: _____
(Signature of Parent/Guardian)