

2015  
FALL WORKSHOP  
REGISTRATION FORM

**» REMINDER**  
You can register online  
At  
[springheights.org/fall-workshop](http://springheights.org/fall-workshop)

PAYMENT:  Church  Personal  
 PayPal Check # \_\_\_\_\_

DATE: \_\_\_\_\_

OFFICE USE ONLY  
NAME: \_\_\_\_\_

YOUTH INFORMATION			
Youth Name:		Date of Birth:	
Gender: Male <input type="checkbox"/> Female <input type="checkbox"/>	Local Church:		District:
Camper Street Address:		I have attended camp _____ times.	
City:	State:	ZIP Code:	Grade 2015-16 Year: _____
Roommate Choice (2) Must be Mutual: _____			

PARENT/GUARDIAN INFORMATION	
Parent/Guardian Name(s):	Home Phone:
Address(if different from camper):	Cell Phone:
City, State, ZIP:	Email Address:

WORKSHOP CHOICES	
Please indicate both a first and second choice for each group in case your first choice is full.	
GROUP A	GROUP B
1. Outdoor Cooking	1. Outdoor Cooking
2. Choir	2. Choir
3. Improv/ Acting	3. Science and Theology
4. Faith Through Art	4. Bible Study
5. Create A Bag	5. Liturgical Dance
6. Hiking	6. What Am I Doing Here?
7. Backpack Program	7. Get "Quad" Up
Group A 1 <sup>st</sup> Choice # _____ Group A 2 <sup>nd</sup> Choice # _____	Group B 1 <sup>st</sup> Choice # _____ Group B 2 <sup>nd</sup> Choice # _____

SHIRT INFORMATION	
Long Sleeve T-Shirt (Included): Shirt orders must be in by November 1 <sup>st</sup> . After this date no guarantee. S: _____ M: _____ L: _____ XL: _____ XXL: _____	
Hoddie Sweatshirt: Purchase \$20.00 S: _____ M: _____ L: _____ XL: _____ XXL: _____	

EMERGENCY CONSENT PERMITTING CARE OF MINORS	
If the staff of the youth event has to bring your child to the Emergency Room facilities for treatment, any person under 18 years of age cannot authorize treatment for him/herself. To assist your child in obtaining treatment, please complete the form below. I, the undersigned parent or guardian, do hereby grant permission for the above named applicant to attend the youth event. In order that my child may receive the necessary medical treatment from the medical staff of an area hospital, I hereby consent to medical treatment for my child for such injury or illness during the youth event and authorize the adult or event staff to obtain such treatment. I hereby release and discharge the responsible adult, event staff, the Conference Council on Youth Ministries, and WV Annual Conference from any and all debts, judgments, or suits of any kind that may arise or be occasioned as a result of the applicant's participation in the youth event. I further acknowledge and understand that while participating in the youth event there is a possibility of physical illness or injury and that my child assumes the risk for such illness or injury by his/her participation.	

Parent/Guardian Printed Name: _____	Signature: _____
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EMERGENCY CONTACT AND MEDICAL INFORMATION (Please attach additional sheet if more space is needed.)			
Name:		Name:	
Relationship	Phone	Relationship	Phone
Special Medical Conditions: Yes <input type="checkbox"/> No <input type="checkbox"/>		Explain:	
Allergies: Yes <input type="checkbox"/> No <input type="checkbox"/>		List:	
Current Medications: (please include over-the-counter)			

PAYMENT INFORMATION		
Payment/Forms Should Be Sent To: Conference Treasurer, Attn: Fall Workshop, PO Box 2469, Charleston, WV 25329		
Who is paying?	Amt. Paid:	Amt. Due: