Community of Christ

Canada East Mission

RETREAT ENROLMENT FORM FOR ADULTS

We are delighted that you have chosen to attend this event. Before completing the enrolment form, please read the privacy policy which summarizes our commitment to protect your personal information.

PRIVACY POLICY

- **We respect your privacy. We protect your personal information and adhere to all legislation requirements with respect to protecting privacy. We do not rent, sell or trade our mailing lists. The information you provide will be used to deliver services and to keep you informed and up to date on activities that we sponsor, including programs, services, special events, funding needs, opportunities to volunteer or to give, and more through periodic contacts.**
- **If at any time you wish to be removed from any of these contacts you can do so by phoning 888-411-7537, or via e-mail dar@communityofchrist.ca and we will gladly accommodate your request.**
- **I have read the Privacy Policy of the Community of Christ and understand that the information I provide will not be shared with any outside party as outlined above.**

Signature_____ **Date** _____

ENROLMENT FORM

Event Attending: _____ **Location:** _____

Name: _____

Phone Email

Address: _____

Street address City Province/State Postal/Zip Code

RELEASE AND WAIVER OF LIABILITY

IN CONSIDERATION of Community of Christ accepting my enrolment I agree to this Release and Waiver of Liability.

- I understand that attendance at retreats involves certain risks and dangers, not all of which can be listed here. Amongst the more obvious and frequent are: hazards in connection with movement about camp and over uneven terrain; hazards in connection with camp sports activities; hazards in connection with travel to and from camp; and hazards in connection with the use of camp buildings and facilities.
- I am not relying on any oral or written statements made by Community of Christ or by anyone representing it, whether such representations are contained in brochures or media form or in individual conversations, to lead me to become involved in the camp programme for which I have applied on any basis other than my assumption of the risks and dangers involved.
- I personally accept all risks and dangers and the possibility of death, personal injury, property damage and loss resulting from my attendance at camp. The risk is accepted for any cause whatsoever on the part of Community of Christ or its employees, agents or representatives.
- I confirm that I have read over this agreement before signing, that I understand it, that I am signing it of my own will and accord and that it will be binding not only on me, but also on my heirs, my next of kin, and my estate trustees.
- I agree that the laws of the Province of Ontario govern this contract and that any legal concerns will be handled in the courts of that Province.

Signature_____ **Date** _____

PHOTO RELEASE

For and in consideration of the undersigned's participation in an activity sponsored by the Community of Christ, I, _____, hereby give my consent and authorize the Community of Christ, its successors, heirs, legal representatives, assigns and agents to use and reproduce my name, voice and/or likeness (photographic, illustrative, audio or video tape, film, electronic and/or digital image), and circulate and use the same for any and all official resource, use or purpose including but not limited to print, film, or electronic media and reproduction or digital representation of every description on the internet/world wide web.

Signature _____ Date _____

MEDICAL INFORMATION

Medical Information for: _____ ***(camper's full name)***

The following questions are for informational purposes only and all answers will be held in strict confidence. This information is required to help ensure your health, safety and, if required, effective medical treatment.

Allergy to foods, medications (if none, so state) _____
_____
_____
_____

Are you currently under a physician's care for any acute or chronic medical condition? Yes___ No___
If yes, please explain _____
_____
_____

Do you carry *non-prescription* medication on their person? (if none, so state) _____
Medication(s) and purpose _____
_____
_____
_____

Do you require *prescription* medication? (if none, so state) _____
Medication(s) and purpose _____
_____
_____
_____

Physician _____ Phone ( ) _____

Health Card Number _____

Permission for Medical Treatment

I, the undersigned, hereby authorize any necessary medical treatment for myself. I also guarantee payment of all charges incurred during this medical treatment (physician, hospital, x-ray, lab, medicines, ambulance, other)

Signature _____ Date _____