

Winter Blitz

Middle School & High School
@ East Iowa Bible Camp - 1433 F52 Trail, Deep River, IA
Feb. 16-18th, 2024

Cost: \$100

Includes: housing lodging, meals, transportation, t-shirt & Activities

Registration Deadline: Jan. 31st
Bring a friend for \$75

Activities includes: Solid Preaching, Great Worship Music, Games, Hanging out,
Connect 4 Tournament, food and much more!!!

_____ (Cut and return with health form to Elise Allee) _____

Registration Form

Student's Name: _____ DOB: ___/___/___ Grade _____

Parent's/Guardian's Name: _____

Best Number to Contact Parent/Guardian in case of emergency:

_____ Do They text: Y/N

Adult T-shirt Size: S M L XL XXL Other: _____

I, _____, (Print Parent/Guardian Name) am giving
_____ (Print Students Name) my permission to attend
Winter Blitz, Feb. 16-18th, 2024.

_____ Parent Signature

Date: ___/___/___

Fellowship Bible Church Youth Group

Health and Injury Information Card and Consent for medical Treatment Form
Please return to Pastor Shawn

Student's Name (Last, First, MI) _____
Date of Birth _____ Age _____ Today's Date _____

Parent/Guardians Name _____

Students Address _____

Father's /Guardian's Phone Number _____ Do they text: Y/N

Mother's/ Guardian's Phone Number _____ Do They Text: Y/N

Father's Place of Work: _____ Phone number _____

Mother's Place of Work: _____ Phone Number: _____

In an emergency, when parent/guardian's cannot be notified, please contact:

_____ Relationship _____ Phone number _____

_____ Relationship _____ Phone Number _____

Date of Last tetanus booster: _____

Does your student wear: glasses Y/ N Contacts Y/N Dentures Y/N

Family Physician _____ Phone _____

Preferred Hospital _____ Phone _____

List of known allergies, drug reactions, or other pertinent medical information
(Diabetes, seizures, history of head injury with unconsciousness or confusion,
medications, etc.)

Please note and date any new injury information here:

Please Copy and attach Insurance card info to this form.

Consent for Medical Treatment

Iowa law requires parent and/or legal guardians' written consent before their son or daughter can receive emergency treatment, unless, in the opinion of an physician, the treatment is necessary to prevent death or serious injury. As the parent(s) or legal guardian(s), of the child named at the top of this card, I (we) authorize emergency medical treatment or hospitalization that is necessary in the event of an accident or illness of my (our) child. I (we) understand that this written consent is given in advance of any specific diagnosis or hospital care. *This written authorization is granted only after a reasonable effort has been made to contact me (us).*

Parent Name Print

Parent Signature

_____/_____/_____

Date