Wesley United Methodist Church 2008 FLIGHT SCHOOL MISSION WEEK YOUTH Registration & Permission Form

Name of Youth: ____________________________________

Address: ____

City/State/Zip: ___________________________________

Telephone # (____) ______ - _________ Birth date: ____________________

E-mail Address: ____

School/Grade: __________________________________ //________ (Currently attending)

<u>Parent/Guardian:</u> Please <u>initial</u> each 'line' and <u>check</u> the appropriate 'box' for each of the following statements.

____ I give permission for my above-named youth to join the Wesley United Methodist Church Youth Group for the following event(s):

☐ **FLIGHT SCHOOL Mission Trip**—July 13 to July 18, 2008 to Copperhill, Tennessee.

____ I understand that he/she will be traveling to and from the project site in either leased or borrowed vehicles.

____ I understand that the cost for these trip is ☐ FLIGHT SCHOOL —**$500.00** and there is a **$100.00** nonrefundable deposit required for this event payable to Wesley United Methodist Church and turned in with this registration form prior to January 1, 2008 to secure my youth's participation.

____ I understand that the remaining balance due can be reduced by my youth participating in church sponsored fundraisers, but it will be **my responsibility** to pay any balance due not covered by his/her participation in church sponsored fund raising events.

____ I understand that the remaining balance of **$400.00** must be paid in full one month prior to the departure date for the mission trip (June 13, 2008).

____ I understand **my youth will be required to participate and support the Wesley UMC youth program.**

____ I release and discharge WUMC, its members, staff, volunteers, and sponsors from any and all liability for any injury, illness, or death caused by, or in any way related to, my above-named child's participation in, or transportation to, the Group Workcamp. In the event of an emergency, I authorize any adult leader of this event, as an agent for me, to consent to any X-ray examination, blood transfusion, medical, dental, or surgical treatment, care or diagnosis advised and supervised by any professional physician, surgeon, or dentist licensed to practice under law where such services are rendered. I expect to be contacted as soon as possible should such services be required.

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Name of Youth: ____

Parent
or
Legal Guardian's Signature: __________________________/ ___________________________
(PRINT NAME) (SIGNATURE)

Date Completed: ____________________

Emergency Phone Contact: _________________________________

Emergency Phone Number: _________________________________

Insurance Company: ______________________________

Policy #: _________________________

Policy Holder's ID #: ___________________________

Allergies/special health problems or concerns:

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Miscellaneous Remarks:

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