FALL RETREAT I I – C.L.U.E.
OCTOBER 21st, 22nd, & 23rd 2011
GRADES 6-12
TOTAL COST: $55 PER PERSON

Camper name: (Last)_____(First)_____
Camper's Mailing Address_____
Phone: ( )_____ Gender: Male Female
Date of Birth: _____
Name of Local Church:_____
Family Health Insurance:
Name of Insurance Company_____
Policy or Group Number_____
Agreement Number_____
Name of Policy Holder_____
Allergies:_____
Medications:_____
Name of Parent or Guardian_____
Day Phone:_____Night Phone:_____Cell Phone:_____

******It is strongly encouraged that your son/daughter stay the entire weekend******
******They will benefit more if they do not miss any time during the retreat******

I, the undersigned, hereby certify that

1. **The above information is correct, to the best of my knowledge.**
2. **My child is able to participate in all aspects, except as noted.**
3. **I give the staff permission to have my child treated at a medical facility in case needed.**
4. **I release the camp management and staff in charge from all responsibility of illness and accidents occurring during my child's stay at camp.**

_____ _____
Signature of Parent or Guardian Date

Mailing address of Parent or Guardian:_____
_____

Mail completed application and $55 by October 15th, 2011 to:
Becky Rodriguez
620 Wesley Chapel Rd
Scottdale PA 15683
Phone 724-887-3990
(PLEASE MAKE CHECK PAYABLE TO CAMP SONRISE MOUNTAIN)