

THE WKND

NAME: _____

GRADE: _____ **GENDER:** _____ **BIRTHDATE:** ___/___/___

PARENT EMAIL: _____

PARENT PHONE NUMBER: _____

STUDENT PHONE NUMBER: _____

GENERAL RULES:

1. STUDENTS ARE EXPECTED TO CONDUCT THEMSELVES IN APPROPRIATE MANNER AT ALL TIMES AND ATTEND ALL SCHEDULED FUNCTIONS
2. STUDENTS MUST STAY IN DESIGNATED AREAS AT ALL TIMES
3. STUDENTS ARE EXPECTED TO RESPECT ADULTS, STUDENTS, AND PROPERTY AT ALL TIMES
4. STUDENTS SHOULD EITHER LEAVE CELL PHONES AT HOME, OR TURN THEM IN WHEN INSTRUCTED TO DO SO
5. STUDENTS WHO MISBEHAVE AND VIOLATE RETREAT RULES WILL REQUIRE EARLY PICK-UP

I HAVE READ AND AGREE TO ABIDE BY THESE RULES: _____

STUDENTS SIGNATURE

CONTINUE ON BACK



Permission/Medical Release Form

New Hope Assembly of God YOUTH Ministries

6800 Townsend Ave. Urbandale, Iowa 50322

PERMISSION

Date _____

I, _____, the parent/guardian of _____, do hereby grant permission for the above to attend all activities with New Hope Assembly of God YOUTH Ministries under the supervision of the appointed leaders. I realize that if my child refuses to adhere to the rules, I will be called to bring them home immediately.

Signed: _____

Address: _____

Phone: _____

Emergency Phone: _____

MEDICAL RELEASE

I/We, _____, being the parents/legal guardians of _____, do further give my/our consent for the properly appointed leader or staff member of the New Hope Assembly of God, Urbandale to secure the administration of medical treatment or medication for the above named child, and I/We do further agree to the performance of such treatment, anesthetics, and operations as the opinion of the attending physician is deemed necessary for our child.

Date _____ Signed _____

Insurance Company _____ Policy Number _____

My child can receive: Tylenol, Ibuprofen, or Antacids as deemed necessary

Yes No

**BELOW, LIST ANY MEDICATIONS OR TREATMENT THAT SHOULD NOT BE GIVEN TO
YOUR CHILD BECAUSE OF DANGEROUS REACTIONS.**

