Friends Workcamp Registration and Medical Permission Form

Dates I will be attending the Workcamp:
_____

Return to:
Friends Workcamps
1515 Cherry St
Philadelphia, PA 19102
Make checks payable to:
"Philadelphia Yearly Meeting"
Memo: For Friends Workcamp

Cost: $55.00
Amount enclosed: $_____
Scholarship requested: $ _____

Donations to the Mary Ritchie Scholarship Fund are greatly appreciated and will enable all who want to come to Workcamps the ability to attend.
Donation: $ _____

Name: _____ Gender: _____ Age: _____
Home address:_____
Phone: (_____)_____ E-mail: _____
Meeting/School/Organization: _____
Date of birth: _____ Grade (if still in school): _____Vegetarian? ____Other Food Sensitivities?_____

College, or boarding school address (if applicable): _____
_____ Phone: (____)_____

Home repair, gardening, childcare or other useful skills: _____
_____

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Emergency Contact:
Name: _____ Relationship: _____
Phone #1: (_____) _____ Phone #2: (_____) _____
Address: _____

Medical and Insurance Information:
Allergies (including food): _____
Medications being taken: _____
Medical conditions that we need to be aware of: _____
_____
Date of last tetanus shot: _____
Family doctor: _____ Phone: (_____) _____
Medical insurance company: _____
Policy number: _____ Group number: _____
Member's name: _____ Is this an HMO? _____

I give permission and consent for my above named child (or self if age 18 or older) to participate in the Philadelphia Yearly Meeting's youth activities. I am fully aware of and appreciate the risks including the risk of catastrophic and permanent injury that may possibly attend such activities. I hereby release Philadelphia Yearly Meeting, its staff and volunteers, from liability for any illness, accident or injury that my child (or I) may sustain during these activities.

"In the event of an emergency, I hereby authorize an adult leader, as agent for me, to consent to any X-ray examination or other diagnostic scan; medical, dental or surgical diagnosis; treatment including hospital care advised and supervised by a physician, surgeon or dentist (as appropriate) licensed to practice under the laws of the state where the services are rendered, either at a doctor's office or in any hospital; and consultation with a mental health professional. I will assume financial responsibility for treatment rendered during this time. If treatment is rendered to my child, I expect to be contacted as soon as possible. I will not hold Philadelphia Yearly Meeting responsible for the payment of any bills incurred because of illness, accidents or injuries to my child (or myself if age 18 or older). I agree to indemnify and hold Philadelphia Yearly Meeting harmless for any loss or expense occasioned by the treatment of my child or myself. I represent that I am authorized to execute this waiver/release on behalf of all the child's parents and/or guardians.

Signature of Parent, Legal Guardian or self (if over 18 or older): _____Date: _____
Note: We have been advised not to accept faxed or photocopied signatures.