Families United Youth Retreat
Trout Lodge Potosi, MO
June 30-July 1, 2018
Registration Form

Please Print (clearly)				
Name: _____ (First Name, Middle Initial, Last Name)	**Sex:** M / F	**Birth Date:** _____/_____/_____ Month Day Year	**Age:**	**Grade:**

Youth Information
Youth lives with (check all that apply): ☐ Biological Parent(s) ☐ Aunt/Uncle ☐ Grandparent(s) ☐ Foster Parent(s) ☐ Other
Youth Race/Ethnicity: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African-American ☐ Hispanic or Latino/a ☐ Caucasian ☐ Other _____
T-Shirts Sizes: S_____ M_____ L_____ XL_____ XXL_____ XXXL_____
Please submit this registration form along with, cash, check or money order made payable to: Families United, in the amount of $165.00 per individual. Retreat includes all meals, accommodations, and transportation. All payments are due on or before June 8, 2018. Deposit of $ 80.00 is due on or before April 30, 2018. Register online at www.healthyrelationshipstl.com or Mail Payment to: Families United P. O. Box 2202, St. Louis, MO 63158. For more information contact Greg or Robin at 314-772-2260 or 314-922-9582. **Deadline June 8, 2018.**

Parent/Guardian Information (Answer the questions below for the primary parent/guardian living in the home)		
Name:	**Relationship to youth:**	
Address:		
City:	**State:**	**Zip Code:**
Daytime Phone:	**Evening Phone:**	
Youth: Food/Environment Allergies? ☐ Yes ☐ No	**If yes,** Important to let us know!	
Signature: _____	**Date:** _____	
Emergency Contact (If Different from Above)		
Name:	**Relationship to youth:**	
Daytime Phone:	**Evening Phone:**	

Office Use Only	
Deposit:	Balance Due:
Online Registration:	Visa/Master Card: PayPal:
Name on Check:	Check Date: Check#
Cash/Check / Money Order Amount:	Final Payment Received:
Signature: _____	Date: _____

IMPORTANT INFORMATION

Physician: _____ Phone: _____ Address: _____

Copy of Insurance Card Enclosed or fill in the information:
Insurance Company _____ Group Number _____ Other information as needed _____

Youth Prescribed	Medication Name	Time of day	Dosage	How Administered

Prescription Medication and/or Over the Counter Medication Release: If your child is taking prescription or over the counter medication while attending camp, the Families United staff must have permission to disperse that medication. I hereby give the Families United health care staff/counselors permission to administer prescription medications as directed by the prescribing physician and described on the form to my child while attending camp.

Every effort is made to keep your child healthy and safe, illness and injuries can sometimes occur. Should a medical emergency occur, you will be notified immediately. If we are unable to reach you and your child needs medical attention, your child will be transported to the Washington Memorial County Hospital, Potosi, MO and treated by the physician on duty.

By signing the following authorizations you are giving your consent in advance for medical treatment.

Emergency Treatment Release
I grant permission to have my son/daughter or ward treated, in the event of an illness or injury, at a medical facility. In the event I cannot be reached, I give permission to the physician selected by the Trout Lodge Camp to secure and administer proper medical treatment, hospitalize, order injection, anesthesia, or surgery for the participant. Furthermore, I hereby state that I am aware and accept the risk inherent in the program activity. The undersigned does herby agree to hold harmless and indemnify the Families United, and the Trout Lodge Camp, their officers, agents, and employees, from any and all liability, loss, actions, or those of this participant, in the course of the camp. I agree to reimburse the Families United for any expense that may incur for medical treatment at Washington Memorial County Hospital, Potosi, MO. The Washington Memorial County Hospital, Potosi, MO or other medical facility will contact you regarding payment for your child's expenses.

Parent Signature _____ Date_____

Families United Healthy Relationship program is designed to support and equip individuals with the skills and knowledge necessary to form and sustain a healthy relationship. **Participants of the program will NOT be coerced or forced into a relationship or encouraged to remain in an abusive or violent relationship. My signature certifies that I understand participation in the program is totally voluntary.**
As part of this program, research may be conducted or statistical information may be gathered. Information from this form will be shared with the Program Evaluator only. Participants will never be individually identified in any statistics or research materials.

I grant permission for photographs taken of my youth to be used in advertising and promotional materials.

Youth Signature_____ Date_____

Parent Signature _____ Date_____