**All attendees** of South Central States Mission Center are **required to pre-register**. Your registration options are:

Reunion: Leslie Brooks, 3028 CR 2700 Independence, KS 67301 email: [lbrooks@cofchrist.org](mailto:lbrooks@cofchrist.org) cell: 620-331-9294

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| Event Selection | | | | | | | |
| Ozark Camp & Retreat Center |  |  | | | |  | |
| July 8th – 14th, 2023 |  |  | | | |  | |
| Camper and Contact Information | | | | | | | |
| Name: | | |  | | | | |
| Full Address Required for Income Tax Receipts  Address | | | | | City / State | | Postal Code |
| Home Phone: | Mobile: | | E-mail: | | | | |
| How did you hear of this event?  Community of Christ member  Other (please specify) | | | | | | | |
| Preferred Accommodation:  Founders  Cabin  Campsite (Note: campsites will be assigned. Please check-in upon arrival) | | | | | | | |
| **Family Members with you (immediate family only):**  Name: | | | | Adult OR Age \_\_\_\_\_\_\_ *(if under 18)*  Entering Grade:  Relationship to you: | | | |
| Name: | | | | Adult OR Age \_\_\_\_\_\_\_ *(if under 18)*  Entering Grade:  Relationship to you: | | | |
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| Name: | | | | Adult OR Age \_\_\_\_\_\_\_ *(if under 18)*  Entering Grade:  Relationship to you: | | | |
|  | | | | Total Registration Fees: $\_\_\_\_\_\_\_\_\_\_\_\_\_ Deposit: -  Amount due on arrival: $\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| Signature | | | | Date | | | |

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| Donations / Registration Fees | |
| Registration fees are for a per day basis which will include; campground rental (electric, water, etc.), meals and housing.  **Reunion : July 8th – 14th registration fees is: Ages 4 – adult $275.00**  **We also have a day fee of: age 4 – adult $50.00 (includes meals).**  Children under 4 years of age is free  These are suggested prices are based on past and expected expenses. Prices have not been adjusted for several years while costs have gone up. Help is available and no one should feel they can’t come to reunion because of cost. At the same time, we encourage everyone to be prayerful about their attendance and recognize that this may involve some sacrifice if they feel strongly about attending reunion.  In order to make these events possible, those who attend events and those who feel passionate about events can make donations to cover the costs incurred. All donations can be made at Registration, given at the Congregation level or mailed to the Reunion Chair. A charitable tax receipt will be issued for the donation amount. | |
| Privacy Policy | |
| We respect your privacy. We protect your personal information and adhere to all legislation requirements with respect to protecting privacy. We do not rent, sell or trade our mailing lists. The information you provide will be used to deliver the services related to the camp, retreat, or other function for which you are registering. If you have questions about the collection or use of this information, please contact the South Central States Mission Center, Leslie Brooks [lbrooks@cofchrist.org](mailto:lbrooks@cofchrist.org) or 620-331-9294 If, at any time, you wish to be removed from any of these contacts, you can do so by phoning Leslie Brooks and we will accommodate your request.  **I have read the Privacy Policy of Community of Christ and, by my signature below confirm I understand the information I provide will not be shared with any outside party as outlined above.** | |
| Release and Waiver of Liability | |
| I understand attendance at camp/retreats involves certain risks and dangers, not all of which can be listed here. Amongst the more obvious and frequent are: hazards in connection with movement about the camp/retreat and over uneven terrain; hazards in connection with camp/retreat sporting activities; hazards in connection with travel to and from the camp/retreat; hazards in connection with the use of camp/retreat buildings and facilities.  I am not relying on any oral or written statements made by Community of Christ or by anyone representing it, whether such representations are contained in brochures or media form or in individual conversation, to lead me to become involved in the camp/retreat program for which I have applied on any basis other than my assumption of the risks and dangers involved.  **I have read the Release and Waiver of Liability. By my signature below, I confirm my understanding of the information and personally accept all risks and dangers and the possibility of death, personal injury, property damage and loss resulting from my attendance at camp/retreat. The risk is accepted for any cause whatsoever on the part of Community of Christ or its employees, agents or representatives.** | |
| Photo Release | |
| In consideration of the right to participate in this activity, by my signature below I hereby give consent to and authorize the taking of photographs or videotapes in which I may appear. I hereby waive all rights of privacy in and to any said pictures, videotapes or web page. | |
| **Signature** | ***Date:*** |

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| Medical Information – Complete a Separate Form for Each Family Member**This medical information is required to help ensure your health and safety while participating in the camp, retreat, or activity for which you are registering. The information is confidential and will be held in strict confidence. It will be shared only with qualified first aid or medical personnel if required. It will be retained for up to twelve (12) months and then destroyed. If you have questions about the collection or use of this information, please contact the Vivian Davidson 1-620-249-2069 or vdavidson@cofchrist.org.** | | | | | | | |
| Name: | | | | | \*Health Card No. | | | |
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| Family Physician: | | | | | Phone | | | |
| Allergies - food, medicine, environmental (if none, so state): | | | | | | | | |
| Special Dietary Restrictions (if none, so state): | | | | | | | | |
| Camp Activity Restrictions:  None  Strenuous activities  Swimming  Other (describe) | | | | | | | | |
| Is camper currently under a physician’s care for any acute or chronic condition?  Yes  No If yes, please explain: | | | | | | | | |
| Does camper carry **non-prescription** medications?  No  Yes - Please list medication(s) and purpose(s): | | | | | | | | |
| Does camper carry **prescription** medications?  No  Yes – Please list dosage instructions and any other helpful information: | | | | | | | | |
| Are there any medications which should not be given (ie. Tylenol, throat lozenge, laxative, etc.): | | | | | | | | |
| Does camper have any history of, or is he/she being treated for the following: | | | | | | | | |
| Anemia  Digestive disorder  High blood pressure  Skin disease | Appendicitis  Epilepsy seizures  HIV  Skin ulcer | Arthritis  Fainting  Hypoglycemia  Sore throats | Asthma  Fractures  Kidney trouble  Tonsillitis | Athlete’s Foot  Headaches  Low blood pressure | | Bronchitis  Heart condition  Nervous System disorder | Diabetes  Hepatitis  Hernia  Other | |
| If yes to any of the above, please explain: | | | | | | | | |
| Please check if any of the following conditions apply to the camper: | | | | | | | | |
| Cramps  Diarrhea  Toothaches  Nosebleeds | Bed Wetting  Constipation  Ear aches | Stomach aches  Frequent colds  Headaches | Homesickness  Fainting  Sleepwalking  Swimmer’s Ear | Hearing problems  Vision problems  Recent emotional upset (death of loved one, divorce of parents, etc.), please explain: | | | | |
| Please describe any other medical, emotional, mental health, dietary or physical condition which could affect the camper’s experience at camp: | | | | | | | | |
| Permission for medical treatment: | | | | | | | | |
| The undersigned, hereby authorize any necessary medical treatment for myself or the above-named (if parent/guardian). I also guarantee payment of all charges incurred during this medical treatment (physician, hospital, x-ray, lab, medicines, ambulance, other). | | | | | | | | |
| Date: **Signature** or Parent/Guardian if camper is under 18. | | | | | | | | |