

UNLIMITED REVOLUTION

Registration Information Sr. High Youth Gathering March 3-5, 2012 Orlando Marriott Lake Mary

The Sr. High Youth Gathering is an opportunity for youth from all over Florida and Georgia to come together and grow in their faith through music, worship, breakout sessions and a great speaker! This event will have a brand new look this year.....a revolution! Pastor Billy will lead this year's gathering as our speaker. We will also participate in a Servant Event right here in our own neighborhood. You won't want to miss it!

The Details:

- We will leave on Friday March 3 from Trinity around 6 PM.
 - We will be traveling by car to Lake Mary
- The Gathering Registration fee is \$80 if paid by January 28th.
 - This does not include food and hotel
 - We will be staying in Lake Mary for 2 nights and the hotel is \$92 a room per night.
 - Once we have an estimate on the number of youth going we will break down the hotel cost.
- We will return around noon on Sunday March 5th
- In order to register you need to complete the attached forms and pay the registration fee no later than January 28th.
 - Registrations that are received after this date must pay an additional \$10.
- If you have any questions please contact Megan Miessler at mirmiessler@trinitydowntown.org

Individual Registration & Emergency Medical Information Form

Church _____
City _____
State _____

Name (Last, First, Middle) _____
Address _____
City _____ State _____ Zip _____
Male/Female _____ Date of Birth _____ Social Security # _____
T-Shirt size (adult sizes): S M L XL XXL
Email: _____ Grade (circle) 9 10 11 12 Adult Leader
Mother's Name: _____ Cell # _____
Father's Name: _____ Cell # _____
Other Emergency Contact: _____
Relationship to person: _____ Phone # _____
Do you have any special needs: _____

Emergency and Health Information (If yes to any questions, please provide explanation and pertinent information)

Date of last Tetanus shot? _____
Do you have:
____ Allergies _____ ____ Heart Condition _____
____ Diabetes _____ ____ Other _____

Do you have a reaction to:
____ Bee Stings _____ ____ Penicillin _____ ____ Other Drugs _____
____ Plants _____ ____ Other _____

Are you subject to:
____ Headaches _____ ____ Seizures _____ ____ Fainting _____
____ Sleep walking _____ ____ Asthma _____ ____ Other _____

Any serious illness or surgery in the past 10 years? _____
Any condition that would prevent participation in activities? _____
Any drugs ineffective in treatment? _____
Sight or hearing impaired? _____
Please list all medications currently being used _____

Please indicate anything else that would be important for adult leaders to know in case of emergency

I will participant fully in the District High School Gathering and seek to help others to do the same.

Participant's Signature _____ Date _____

Parent's/Guardian Signature (for those under 21) _____ Date _____

Primary Adult Leader's Signature _____ Date _____

Medical and Liability Release Form

RELEASE OF ALL CLAIMS

(To be completed by adult participants and the parents/guardians of youth participants)

In consideration for participation in the 2012 Florida/Georgia District High School Gathering, “*UNLIMITED REVOLUTION*”, we/I, being 21 years of age or older, do for ourselves/myself (and for and on behalf of our/my “Child-Participant” if said child is not 21 years of age or older) do hereby release, forever discharge and agree to hold harmless the Florida/Georgia District of the Lutheran Church Missouri Synod, the Lutheran Church-Missouri Synod, and _____ (name of home congregation) and any directors, employees or agents therefrom (hereinafter collectively referred to as Designee”) thereof from any and all liability, claims or demands for personal injury, sickness or death, as well as property damage and expenses, of any nature whatsoever which may be incurred by the undersigned and the Child-Participant that occur while said child is participating in the above-described trip or activity.

Furthermore, we/I [and on behalf of our/my Child-Participant if under the age of 21 years] hereby assume all risk of personal injury, sickness, death, damage and expense as a result of participation in recreation and work activities involved therein.

Further, authorization and permission is hereby given to said Designee to furnish any necessary transportation, food and lodging to this Child-Participant.

The undersigned further hereby agree to hold harmless and indemnify Designee, for any liability sustained by said Designee as the result of the negligent, willful or intentional acts of said Child-Participant, including expenses incurred attendant thereto.

Consent is given to the photographing of Child-Participant and the recording of Child-Participant’s voice and the use of these photographs and/or recordings singularly or in conjunction with other photographs and/or recordings for advertising, publicity, commercial or other business purposes. It is understood that the term "photograph" as used herein encompasses both still photographs and motion picture footage. Further consent is given to the reproduction and/or authorization by the Florida/Georgia District LCMS to reproduce and use said photographs and recordings of Child-Participant’s voice, for use in all domestic and foreign markets.

(if the participant has not attained the age of 21 years):

For the period from _____ to _____, we/I are the parent(s) or legal guardian(s) of this Child-Participant, and hereby grant our/my permission for him/her to participate fully in said trip, and hereby give our/my permission, in accordance with this authorization and pursuant to the Health Information Portability and Accountability Act of 1996 and its progeny, (See Exhibit “A” Attached hereto) to take said Child-Participant to a doctor or hospital and hereby authorize medical and/or dental treatment, including but not in limitation to emergency surgery or medical and/or dental treatment, and assume the responsibility of all medical/dental bills, if any

Further, should it be necessary for the Child-Participant to return home due to medical reasons, disciplinary action or otherwise, we/I hereby assume all transportation costs.

Type or Print full name of Child-Participant

(Father) (Mother)

(Parent or Legal Guardian Signature) (Participant signature, if age 21 or older)

Hospital Insurance _____ Yes _____ No
Insurance Company: _____ Policy # _____
Physician _____ Phone # _____

EXHIBIT "A"
AUTHORIZATION FOR USE OR DISCLOSURE
OF PROTECTED HEALTH INFORMATION

This is an authorization under the Privacy Rules of the Health Insurance Portability and Accountability Act of 1996 [45 CFR§164.508]. We/I authorize any healthcare provider, hospital, EMT, ambulatory surgical center, walk-in health care clinic, emergency room doctor, nurse or other health care provider/entity to obtain and/or release protected health information (PHI) regarding "Designee" as set in the "Medical and Liability Release Form", for the purposes of:

- ___ obtaining protected health information from Designee or any other health care provider for the purposes of providing emergency treatment and care to "Child Participant" as that term is defined in the "Medical and Liability Release Form;
- ___ use the following protected health information, and/or
- ___ disclose the following protected health information to any Designee, or its director(s) employee(s), or agent(s), including, without limitation, [*Name of entity or person(s) to receive information*]:

Florida Georgia District of the Lutheran Church—Missouri Synod
Lutheran Church Missouri Synod

In addition to the above, the names or class of people authorized to use or disclose are as follow:

The PHI authorized herein is being used and/or disclosed in order to provide treatment and care to Child Participant and to obtain medical information about said Child Participant's illness, injury, or medical condition.

This authorization shall be in force and effect beginning on _____ and shall remain in full force and effect until _____ date or (2) upon such time as the Parent(s) and/or Guardian(s) are present or able to demonstrate their legal responsibility to assume such authority to obtain and disclose PHI at which time this authorization to use or disclose this authorization expires.

We/I understand that we/I have the right to revoke this authorization, in writing, at any time by providing such written notification to the healthcare provider at the address where such health care is being rendered and to the attention of the healthcare provider. We/I also understand that a revocation is not effective to the extent that the healthcare provider has relied on the use or disclosure of the protected health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

We/I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

The healthcare provider will not condition his/her/its treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether we/I provide authorization for the requested use or disclosure except: (1) if our/my treatment is related to research, or (2) health care services are provided to us/me solely for the purpose of creating protected health information for disclosure to a third party.

This Authorization for Use and Disclosure of PHI is NOT extended to any marketing efforts, which might benefit the treating healthcare provider or entity,

Signed by us/me this ____ day of _____, 2012.

Father

Mother

Name:_____

Name:_____

Legal Guardian

Legal Guardian

Name:_____

Name:_____

Print Name of Patient Above