Episcopal Diocese of Texas - Y.E.S. YOUTH PARTICIPANT Application

7th – 9th Graders Only

(One adult sponsor per church is required to attend with Y.E.S. participants)

Please mail application and $65.00 to: Y.E.S. c/o Division of Youth, 1225 Texas Avenue, Houston, TX 77002
Make checks payable to Episcopal Diocese of Texas
Scholarships are available (simply write "scholarship needed" on application to receive $22 off cost).

The Y.E.S. application is due two weeks before the Y.E.S. weekend you wish to attend.

Name _____ M or F____ What You Go By _____

Age ____ Address _____ City _____State _____Zip _____

Email address you use with friends _____

Home Church _____ City _____ Birth Date _____Grade ____

Parent/Guardian Name _____Phone (____)_____

Parent/Guardian Email _____ Parent/Guardian Cell Phone (____)_____

Please Circle T-Shirt Size: (adult sizes) Small Medium Large X-Large XX-Large

Please circle the Y.E.S. you wish to attend:

Y.E.S. # 99 (August 20-22, 2010) Y.E.S. # 100 (November 19-21, 2010)

Y.E.S. # 101 (January 21-23, 2011) Y.E.S. # 102 (April 29-May 1, 2011)

Permission/Release

I/my child, _____, has my permission to attend and to participate in YES, to be held at Camp Allen in Navasota, TX sponsored by the Episcopal Diocese of Texas. I represent that my child/self is healthy and capable of participation in said event without causing risk of danger, illness or accident to him/herself, or to others. I agree to hold harmless the leaders of my church, leaders of other churches involved, the event coordinators, the Bishop of Texas and the Diocese of Texas in the event of any accident or injury. In the event that my child requires medical attention while attending the event, I understand that an adult sponsor of the event will make every reasonable attempt to contact me. In the event that I cannot be contacted, I consent to any medical attention deemed appropriate. In the event that treatment is called for, which the medical provider refuses to administer without consent, I hereby authorize an adult sponsor to give such consent for me if I cannot be contacted immediately, or because of an emergency, there is no time or opportunity to make contact. In the event that it is necessary for that person to give consent, I agree to hold such person free and harmless of any liability for damages arising from giving such consent. Please list all allergies, medical problems, medications currently being taken by participant, or any other pertinent information below. Please notify the Event Coordinator or Nurse if this participant has been exposed to any communicable disease 3 weeks prior to this event. I declare that my child/self is covered by medical insurance and/or that I am responsible for any and all expenses incurred by my child/self whether covered under insurance or not. **(NOTE: The Sponsors of this event do not provide insurance in case of injury or illness.)**

ADULT/PARENT/GUARDIAN SIGNATURE _____ Relationship to Participant _____Date _____

Note: This form must be signed by a church sponsor to be accepted.

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I have known this person for _____ years and feel that they would benefit from the Y.E.S. Experience.

YOUTH MINISTER or PRIEST SIGNATURE_____ Date _____

Print Youth Minister or Priest Name_____ Church/City _____

Please complete both pages of this application

Please tell us why you are interested in attending Y.E.S. as a participant:

_____

_____

_____

_____

_____

_____

Medical and Insurance Information

HEALTH CARRIER, POLICY #, GROUP #: _____

(IMPORTANT: ATTACH COPY OF BOTH SIDES OF INSURANCE CARD)

HEALTH CARRIER ADDRESS: _____

HEALTH CARRIER PHONE #: _____

ALLERGIES, REACTION, TREATMENT: _____

_____

FOOD ALLERGIES, DIET RESTRICTIONS: _____

_____

CHRONIC OR RECURRING ILLNESSES (Asthma, migraines, etc): _____

_____

MEDICATIONS BEING SENT WITH PARTICIPANT: _____

_____

ANY OVER THE COUNTER MEDICATIONS THAT THE PARTICIPANT MAY NOT RECEIVE:

(For example: Tylenol, Advil, Kaopectate, etc.) **NO -** _____ **If Yes, Please List all:**

_____

_____

_____

_____

(NOTE: Prescribed Medicines must be in original pharmacy container with correct name, date, instructions, and physician's name on label)

EMERGENCY CONTACT NAME AND RELATIONSHIP: _____

CONTACT PHONE # - HOME - _____ CELL - _____

SECOND CONTACT NAME AND RELATIONSHIP: _____

CONTACT PHONE # - HOME - _____ CELL - _____