

CPYM Fall Retreat Registration Form

Please complete all sections clearly and return with payment.

Participant Information

NAME: _____ SCHOOL: _____ GRADE: _____

ADDRESS: _____ City: _____ State: _____ ZIP: _____

DOB: _____ AGE: _____ SEX: M / F

Requested Roommates:

1. _____ 2. _____ 3. _____

Health Insurance Company: _____ Group #: _____ Policy #: _____

Authorization and Consent

I, _____, the legal parent/guardian of _____,

Print Parent/Guardian Name

Print Child's Name

do hereby release Central Pennsylvania Youth Ministries from any, and all liability in case of accident or illness and authorize any medical care deemed necessary by an accredited physician, nurse or hospital while attending above mentioned function. I hereby assume all responsibility for his/her conduct, and for any damage my child does to the camp property or property of CPYM, with the understanding that I will pay for all damages. Any violation of the code of conduct will mean that I must provide immediate transportation home for my child. The use or possession of alcohol, illegal drugs, any sexual conduct that is illegal, cigarette smoking, vapes, or failure to refrain from inappropriate touching, and any form of verbal physical harassment by my child will be a violation of CPYM's code of conduct. I permit CPYM to use photographs of my child in publications and publicity material and for inclusion in the CPYM Image library. I request the camp nurse to administer the following medications to my child while attending this camp if I had provided the appropriate paperwork. I understand that the signed medical order form from the prescribed doctor must accompany each prescription. I have attached all necessary paperwork. I request the following over-the-counter medications be given by the camp nurse.

I understand that my child will be supervised by responsible adults with clearance background checks. I understand that in no event will CPYM, participating local churches, camp, staff, volunteers be held responsible for loss of property, nor injury or death due to an accident.

I do hereby give my permission to the staff of CPYM to obtain and administer such medical aid or assistance as might be required for the immediate care of my child in the event such help of any emergency nature becomes necessary. I am responsible for payment of any medical charges/expenses not covered by my insurance or the insurance applicable to my child (if any).

My signature below indicates that ALL information provided on this form is true and accurate, and that I fully agree to all statements made on the form, including but not limited to the Authorization and Release of Liability, Medical Conditions, and Consent to Medical Treatment.

X _____ Date: ___/___/2026 Phone #: _____ - _____ - _____

Parent/Guardian Signature

(In Case of Emergency)

Medication Permission - Please check all medications that your child may receive:

Acetaminophen Antacid Calamine lotion Ibuprofen Benadryl

Other: _____

Allergies and Medical Conditions

Medical Conditions/Concerns: _____

Food allergies (detailed list): _____

Other allergies or important notes: _____

Mailing Information

Mail Registration and Payment to:

Central PA Youth Ministries
P.O. Box 33, Thompsettown, PA 17094

OFFICE USE ONLY

Total Cost: _____	Amount Received: _____	Check / CASH / ACH	Balance Due: _____	Date: ___/___/2026
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Registration Cost: \$180 / Late Registration Cost: \$250 after Monday, October 5, 2026.