

## REFUGE IN THE ROCKIES 2008 REGISTRATION

**Mail to:**

Colorado Springs Church of God (7<sup>th</sup> Day)  
Attn: Brian Franks  
PO Box 62178  
Colorado Springs, CO 80962  
Or email: [office@cscog7.org](mailto:office@cscog7.org)

**Cost:** \$275 before May 1<sup>st</sup>  
\$305 from May 1<sup>st</sup>-June 21<sup>st</sup>  
\$325 first day of camp  
(payable online at [www.cscog7.org](http://www.cscog7.org) or  
make checks payable to **CSCOG7**)

First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_ Last Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone Number: (\_\_\_\_)\_\_\_\_ - \_\_\_\_\_  
Email Address: \_\_\_\_\_  
Age: \_\_\_\_\_ Gender: Male  Female

**Emergency Contact Names and Numbers:**

Day: \_\_\_\_\_ Number: (\_\_\_\_)\_\_\_\_ - \_\_\_\_\_ Relationship: \_\_\_\_\_  
Night: \_\_\_\_\_ Number: (\_\_\_\_)\_\_\_\_ - \_\_\_\_\_ Relationship: \_\_\_\_\_

Mother (if not one of the above): \_\_\_\_\_ Number: (\_\_\_\_)\_\_\_\_ - \_\_\_\_\_  
Father (if not one of the above): \_\_\_\_\_ Number: (\_\_\_\_)\_\_\_\_ - \_\_\_\_\_

What medications do you take and for what purpose?

\_\_\_\_\_

Are there current medical treatments or conditions that we should be aware of?  Yes  No  
If **YES**, please list such conditions:

\_\_\_\_\_

The Church of God (Seventh Day) does carry limited insurance, but the following information may be needed to speed medical attention should it be necessary.

Do you have insurance?  Yes  No

If **YES**, answer the following:

Name of Insurance Company: \_\_\_\_\_

Name of primary Insured: \_\_\_\_\_

Group Number: \_\_\_\_\_

Plan Number: \_\_\_\_\_

I hereby release Temple Hills Camp and Retreat Center, the Colorado Springs Church of God (7<sup>th</sup> Day) and all camp staff from any and all liabilities that might arise based upon my willing participation in any provided and official camp activities. I also agree to abide by any and all rules of camp that are posted or read to me orally while at camp. I understand that any medical or dental costs that might arise during my stay at camp will be my own responsibility.

\_\_\_\_\_  
Signature (Parent or Legal Guardian if under 18)

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date