West Central Region Youth of Unity Medical/Liability Release

Name of Minor_____ Gender: F___ M ___Other ___

Birth date (mo/day/yr) ___/___/___ Age (yrs/mos) ___/___ Vegetarian ___ Gluten-Free_____

Name of Parent or Legal Guardian_____

Street Address

_____

City _____ State _____ZIP_____

Phone#1_____ #2_____ #3_____

Email: parent _____ teen _____

The above identified minor has my (above parent/guardian) permission to travel to and participate in all activities related to the February 2025 Leadership Retreat sponsored by the West Central Region Youth of Unity at Unity of the Valley Spiritual Center February 28-March 1, 2025, and further, whenever it may be deemed necessary, I authorize the calling of a doctor and/or the providing of other medical services for the above named minor and agree to pay for these services. I understand that reasonable measures will be taken to safeguard the health and safety of the above-named minor. However, I agree to indemnify and hold harmless the West Central Region Association of Unity Churches and Youth of Unity, their ministers, employees, agents, sponsors, representatives and group leaders from all liability arising from the above named minor's travel to and from, attendance at and participation in February 2025 Leadership Retreat and related activities, no matter how caused, whether it result from negligence of the West Central Region Association of Unity Churches and Youth of Unity, their ministers, employees, agents, sponsors, representatives and group leaders or otherwise.

I Certify that the above-named minor is in good health and able to participate in all normal activities of this event: YES____ NO____ If "no," describe the nature of the limitations and the limits of their participation:

_____

Is the above-named minor currently under a doctor's supervision or care: YES____ NO_____

If "yes," is it for: Asthma ____ Diabetes ____ Epilepsy ____ Other(specify)_____

Is the above-named minor currently taking medication: YES___ NO___ If "YES," Specify medication and purpose _____

If the above-named minor is allergic to any food or medication? If "yes" specify_____

Medical Insurance (Company & policy #) _____

Family physician: Name: _____ Phone _____

Signature of Parent/Guardian_____Date: _____/2025

YOU sponsor Signature_____ Date: _____/2025

Church_____ Minister_____