West Central Region Youth of Unity
Medical/Liability Release for Leadership Retreat 2026

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…….
e- mail: parent.....teen.....

The above identified minor has my (above parent/guardian) permission to travel to and participate in all activities related to the Leadership Rally 2026 sponsored by the West Central Region Youth of Unity at Spiritual Life Center in Sacramento, on February 20th through February 21st 2026, 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 Leadership 2026 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:..../...../2026
YOU sponsor Signature..... Date:..../...../2026
Church.....Minister.....