

# BLAST 2012

WINTER CONFERENCE  
FEBRUARY 17-20, 2012

## Student Registration Form

1. This completed form along with a \$100 deposit is **due Sunday, January 15, 2012**.  
**Registrations received after the deadline are subject to a \$25 late fee.** Make checks payable to Community Christian Church.
2. Turn in form at a Community Campus or mail to Community Christian Church, ATTN: Tim Raad, 1635 Emerson Ln, Naperville, IL 60540
3. You may also register online at **www.communitychristian.org/blast**. Conference schedule, departure and arrival details, recommended packing list, as well as other details are online.

### Student Information

Name \_\_\_\_\_ Gender \_\_\_\_\_ Grade \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Church/Campus \_\_\_\_\_

Roommate Preference \_\_\_\_\_

Emergency Contact Name \_\_\_\_\_ Phone \_\_\_\_\_

Relationship to Student \_\_\_\_\_

Parent Email \_\_\_\_\_

#### Conference Cost \$225

*Includes lodging, meals, transportation,  
Theme Park Entry (Sun) and Indoor  
Water Park entry (Sat and Sun)*

#### Optional Activity - High School Only\*

Skiing - No Equipment \$40  
Skiing - Equipment Rental \$65  
\* Must sign Cascase Mountain Waiver

**\$100 Due by January 15 - Final Balance Due on February 17**

**TOTAL COST**

Conference Cost	\$225
Skiing Cost (optional)	_____
<b>Total</b>	_____
Paid Today	_____
Final Amount Due	_____

### General Release / Hold Harmless Agreement

The undersigned or a member of the immediate family of the undersigned desires to participate in various programs, events, or activities (herein collectively referred to as "Activities") operated or sponsored by Community Christian Church (herein referred to as the "Church"). The undersigned or a member of the immediate family of the undersigned further understands and acknowledges that the undersigned or a member of the immediate family of the undersigned may incur injury or bodily damage while participating in such Activities. The undersigned or a member of the immediate family of the undersigned further understands and acknowledges the Church will not allow the undersigned or a member of the immediate family of the undersigned to participate in such Activities without releasing and holding harmless the Church. Further, the undersigned or a member of the immediate family of the undersigned requests the Church to allow them to participate in Church Activities and in consideration thereof agree to hereby release and forever discharge the Church, their officers and their directors and their employees, their agents and any parties volunteering on behalf of the Church, from all actions, claims, costs, expenses or damages of any kind growing out of or related to any Activity of the Church in which the undersigned or a member of the immediate family of the undersigned participates. The undersigned or a member of the immediate family of the undersigned further acknowledges that this is a full and complete release for all injuries and damages which the undersigned or a member of the immediate family of the undersigned may sustain as a result of the undersigned or a member of the immediate family of the undersigned's participation in any Church program.

SIGNED: \_\_\_\_\_ Dated: \_\_\_\_\_ Relationship: \_\_\_\_\_

### Medical Release

I, \_\_\_\_\_ being the legal guardian of \_\_\_\_\_ give my permission for him /her to attend **Blast at Kalahari Resort in Wisconsin** under the direction of Community Christian Church. The undersigned, being a parent and/or legal guardian of the above minor, does hereby authorize the treatment of the above minor by a qualified and licensed medical doctor in the event of a medical emergency, which, in the opinion of the attending physician, may endanger his / her life, cause disfigurement, physical impairment or undue discomfort if delayed, while said minor is participating in the above event, including transportation to and from the event site. This authority is granted only after a reasonable attempt has been made to contact me.

SIGNED \_\_\_\_\_ Dated: \_\_\_\_\_

Specify Medical Allergies, Chronic Illnesses or other Medical Conditions: \_\_\_\_\_

Insurance Provider \_\_\_\_\_ Group# \_\_\_\_\_ Policy # \_\_\_\_\_