



2008 Mother Daughter Retreat

The 2008 Mother Daughter Retreat
Friday, April 25 beginning at 7pm to
Sunday, April 27 at 11:00.
\$25.00 per camper!

This special gathering began in 1991. Through the years many have returned because of the opportunity to spend quality time together as a family; mother/daughter and grandmother make it three generations in some cases.

- We will worship, sing, laugh, eat and play together in this beautiful, relaxing setting.
- This is a good time for youngsters to come to White Camp with Mom or Grandma to get acquainted with the camp. Then they'll be ready to come to summer camp.
- You will be asked to bring food items to share for meals and snacks.
- We will divide this among those who register for the event.
- Use the registration form below.
- Please register by April 11th.

Yours in Christ,
Co-Directors: Nancy Fike & Janet Hunt



| 2008 Mother/Daughter Retreat Registration Form | |
|--|--------------------------|
| Please register my daughter and me for the Mother/Daughter Retreat. I will be our family unit's responsible party. I have enclosed the full registration fee. | |
| My full name is: | |
| My daughter's full name: | |
| Joining us will be: | |
| (If the person joining you is a minor and not a member of your immediate family, please have her parent/guardian fill out the Medical Release Form below. Bring this form with you.) | |
| My address is: | |
| My phone number is: | My cell phone number is: |
| My address is: | |
| My E-mail Address is: | |
| Send this registration form and fee to: Kansas-Oklahoma Conference, % of Judy Vincent, UCC, 1245 Fabrique, Wichita, KS 67218 | |

Medical Release Treatment Form

This signed Emergency Treatment Form will be kept by the Responsible Party of each family unit for those attending the 2008 Mother/Daughter Retreat between April 25 and April 27th. Permission is granted the person listed below to authorize treatment by a health care provided if my child becomes ill or is injured during this afore mentioned retreat.

| | | | |
|-------------------------------|-------------|------------------------|------|
| Name of minor: | Height: | Weight: | Age: |
| In case of emergency, notify: | | Relationship to minor: | |
| Home Phone: | Work Phone: | Cell Phone: | |
| Name of Minor's Physician: | | Phone: | |
| Medications/Allergies: | | | |

Emergency Treatment Authorization

In the event that I cannot be reached in an emergency, I hereby give my permission to the physician selected by the responsible party named below to hospitalize, secure proper treatment, and to order injection and/or anesthesia and/or surgery for my child, as named above.

| | |
|--|-------|
| Name of Responsible Party: | |
| Signature of Parent/Guardian | Date: |
| Name of Insurance Company which covers my child: | |
| Policy Number: | |