

**EMERGENCY INFORMATION**

This form grants the permission for the treatment of minors when a parent/guardian cannot be contacted, through the unlikely event of accident or illness, every reasonable attempt will be made to reach the parent/guardian listed below.

**EMERGENCY CONTACT**

Relationship to *REMIX* Participant: \_\_\_\_\_ Phone #1: \_\_\_\_\_

Relationship to *REMIX* Participant: \_\_\_\_\_ Phone #2: \_\_\_\_\_

**PERMISSION & RELEASE || TERMS & CONDITIONS**

Parental consent is required for all minors. Adult participants need to agree below as well.

I grant permission for my child or me to attend and participate in *REMIX*. I consent to emergency medical treatment in the unlikely event of accident or illness during the *REMIX* week.

I hereby release the *REMIX* event staff, their associates, Youth Unlimited (Toronto YFC) its associates/volunteers, the hosting facility and its employees from any and all liability that may result from the participant's involvement in *REMIX*.

I, and my insurance company, assume full responsibility for the payment of any and all medical costs.

We, the parent/guardian and participant, also give the *REMIX* event staff the right to use the participant's image in future promotional material.

Parent/Guardian (print name): \_\_\_\_\_

Parent Guardian Signature: \_\_\_\_\_

*REMIX* Participant (print name): \_\_\_\_\_

*REMIX* Participant Signature: \_\_\_\_\_

Today's Date (MM/DD/YYYY): \_\_\_\_\_

**REMIX RATES**

Early Bird Rate: **\$419** (April 20, last day)

Regular Rate: **\$444** (May 18, last day)

Late Rate: **\$469** (May 19 - June 27)

PERSONAL INFORMATION

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Email: \_\_\_\_\_  Student  Adult

Church Name: \_\_\_\_\_ City: \_\_\_\_\_

Female  Male Grade Completed This Year (circle one): **8** **9** **10** **11** **12**

DIETARY CONCERNS:

I have the following allergies, special dietary requirements, and health concerns:

\_\_\_\_\_  
\_\_\_\_\_

HEALTH INFORMATION:

I require the following medication(s) on a daily/regular schedule:

\_\_\_\_\_  
\_\_\_\_\_

Health Insurance Carrier: \_\_\_\_\_

Health Insurance Policy Number: \_\_\_\_\_

Ontario Health Insurance Plan (*Ontario Residents Only*): \_\_\_\_\_

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