

Sweetheart Leadership Camp 2010  
Feb 12<sup>th</sup>-14<sup>th</sup> Friday 8pm- Sunday 2pm

Name: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Age: \_\_\_\_\_

Chapter: \_\_\_\_\_

List all titles Current & Past: \_\_\_\_\_

\_\_\_\_\_

Why are you attending camp: \_\_\_\_\_

\_\_\_\_\_

List any special needs for camp: \_\_\_\_\_

\_\_\_\_\_

Have you ever been to SLC before: Yes No

Price for camp is \$45.00 pre-registration \$60.00 at the door!

Included: Food, Folder, Crafts and a lotta FUN!

What to bring: Sleeping bag, pillow, clothes, a good attitude!

What not to bring: Cell Phones, Ipod's, Radios, etc.

Contact Info: SCJ Sweetheart Elizabeth (818) 667-8386  
or SCJ Princess Rachel (909) 638-3482

'RAISE YOUR VOICE at SWEETHEART LEADERSHIP CAMP'

# MEDICAL RELEASE FORM

## Southern California DeMolay Leadership Camp 2010

I, the undersigned as an adult or Parent/Legal Guardian of \_\_\_\_\_, do hereby give my consent and permission for him to participate in the Southern California DeMolay 2010 Councilor Leadership Camp, February 12 – 15, 2010.

In the event of any injury or illness to the above named minor, I hereby authorize any adult DeMolay Advisor in attendance to secure, and any physician in attendance to provide, such emergency medical treatment as shall be deemed necessary by those present; including but not limited to hospitalization, injections, anesthesia, surgery, x-ray, blood and medications. I understand that every reasonable effort shall be made to contact me prior to medical treatment.

**The above named is subject to the following medical problems, and/or is receiving treatment under supervision of proper medical authorities as follows: (State on lines below. If none, state NONE.):**

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Neither DeMolay International nor the Jurisdiction of Southern California, Order of DeMolay, maintains any medical insurance for its members. I understand that I will be responsible for any and all costs of medical treatment incurred by or on behalf of \_\_\_\_\_. My family health insurance carrier and policy number are as follows:

Insurance Company Name	Policy Number	Policy Holder's Name
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In the event of an emergency and the undersigned parent or guardian cannot be reached, the undersigned parent or guardian hereby authorizes the following person to act on their behalf:

Name: \_\_\_\_\_ Phone: (    ) \_\_\_\_\_

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

Relationship: \_\_\_\_\_

Parent or Legal Guardian: Please print or type the following information about yourself:

Full name: \_\_\_\_\_ Relationship: \_\_\_\_\_

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

Zip: \_\_\_\_\_ Day time Phone: (    ) \_\_\_\_\_ Night: (    ) \_\_\_\_\_

\_\_\_\_\_  
Signature of Adult, Parent or Guardian

\_\_\_\_\_  
Signature of Sweetheart