<u>CHALLENGE RETREAT REGISTRATION</u>

NAME ______________________________ PHONE ______________

ADDRESS ____

CITY/STATE/ZIP ____

PARISH _______________________ CITY _____________________

MEDICAL INFORMATION

Special dietary considerations: ______________________________

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Allergic reactions: ____

____

Asthma or airway constricting prescription medication: _________

____

Physical limitations: ____

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MEDICAL EMERGENCY CONTACT INFORMATION:

Name & Relationship __________________ Phone _____________

Name of Doctor ______________________ Phone _____________

Health Plan Carrier __________________ Policy# ______________

NOTE: REGISTRATION IS FIRST COME, FIRST SERVED/DEADLINE IS WED., DECEMBER 27!