

# Girls Night

Friday February 10th

6:00pm-10:00am

Cost: \$10

**Bring:**  
**-Permission Slip**  
**-Sleeping Bag/Pillow**  
**-PJs**

**Where: The Boice's**  
**260 Avenida Vista Montana Apt.25N**  
**San Clemente, CA 92672**

CONTACT:  
RACHEL BEARD  
RACHELB@CAPOBEACHCALVARY.COM  
(949) 493-2006 EXT.232/(760) 481-9347

## Medical/Liability Release Form

I give permission for my child to join **Straight Up Youth Ministry** for its trips and /or events. I understand the group will be maintained with adequate supervision and that alcohol, smoking, and drugs will not be permitted at any time and if at any time my child is found using, I will be notified to pick them up at that time. **Capo Beach Calvary**, its staff and leaders reserve the right to search any bag if there is reasonable cause.

I, the parent or legal guardian of the child listed below, hereby release **Capo Beach Calvary**, its staff and leaders, from any and all claims resulting from injury or damage that may be sustained by my child while participating in the trip and/or events of **Straight Up Youth Ministry**. I hereby release responsibility and liability for any injury or illness that my child may sustain during the trips and /or events. In the event of an emergency, I hereby authorize an adult leader of the trip and/or event, as agent for me, to consent to any X-ray examination, medical, dental, or surgical diagnosis, treatment, anesthesia, and hospital care advised and supervised by a physician, surgeon, or dentist (as appropriate) licensed to practice under the laws of the state where the services are rendered, either at a doctor's office or in any hospital for my child's well-being. I expect to be contacted as soon as **possible**.

**Please be advised that by signing below you agree to all terms stated above and hereby release your child into the care of Straight Up Youth ministry on all trips and/or events.**

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

Student Signature: \_\_\_\_\_

Parent/legal guardian Name: \_\_\_\_\_

Parent/legal guardian Signature: \_\_\_\_\_

Emergency Contact Number:

\_\_\_\_\_

Insurance Provider and Policy Number:

\_\_\_\_\_

Please list any medical conditions we should be aware of:

\_\_\_\_\_

Date of Birth: \_\_\_\_\_ M F

School: \_\_\_\_\_

Grade: \_\_\_\_\_