Search me God and know my heart Test me and know my anxious thoughts

December 27-29

Ages 13 & up $65 (all meals included)

Please do not mail applications after Dec 7th as they will not arrive in the mail on time. Bring it with you. Thanks!

Name: _____ Age: ____ Gender: M F
Address: _____ Phone Number: _____
City: _____ State: _____ Zip: _____
Email: _____
Church attend: _____ Pastor: _____

In case of emergency, notify: _____
Phone Number: _____
Relationship to retreater: _____

Retreaters must be 13 by Dec 27th in order to attend

Mail applications to: **Mykala Shaver**
16011 Prairie Way
Basehor, KS, 66007

Make checks payable to: **Church of God of Prophecy**

Questions? Contact me at *mykala.shaver@heartlandcogop.org* or *660-441-5869*

Retreat location:

Cross Pointe Camp and Retreat Center
31434 Main Street, Rocky Mount, MO

It is located on the Lake of the Ozarks at the 6 mile marker. The campground is at the end of Y Highway off of Highway 5 out of Eldon, Missouri. Follow the signs to Cross Pointe. If you drive into the lake, you've gone too far. ☺

There will be a snack shack, so bring some money for that, if desired. You'll also want to pack bed linens, bathroom linens, personal hygiene supplies, and clothes for activities and church. Most importantly, bring your Bible, some note-taking materials, and a great attitude. Can't wait to worship with you!

Winter Retreat 2013

See if there is any offensive way in me And lead me in the way everlasting

Psalm One Thirty Nine

Medical Information

Please indicate with a check mark any of the following medical problems that apply to the retreater. If it is a current problem, please provide date of the most recent occurrence; if a past problem, approximate date.

	Rheumatic Fever:		TB:
	Diabetes:		Heart trouble & related problems:
	Asthma:		Ivy, Oak, Sumac poisoning:
	Convulsions:		Fainting:
	Sleep walking:		Kidney trouble:
	Recent Illness:		Other: :

Allergic Reactions to: _____

Most Recent tetanus shot:_____ Blood Type_____

Medications taken on a regular basis:
_____ Treating_____ Frequency_____
_____ Treating_____ Frequency_____
_____ Treating_____ Frequency_____
Other Pertinent Information _____
_____

NOTE: Medications must be in original container & administered by retreat staff; no exceptions!

****** ATTACH A COPY OF THE FRONT AND BACK OF YOUR INSURANCE CARD ******

MEDICAL CONSENT: In case of an emergency, I understand that every effort will be made to contact me (parent or guardian). In the event I cannot be reached, I hereby give permission to the Retreat Director and physicians selected by the retreat to secure proper treatment for, to administer "over-the-counter" (OTC) or prescription medications, to hospitalize, order injection, anesthesia, and/or surgery for the retreater. I understand that my insurance has the primary responsibility of payment should my child need treatment. The retreat insurance is secondary. I understand that all medications, including OTC must be administered by the retreat director and that medications will be collected at time of registration.

Insurance Company_____Policy #_____Group/ID #_____

Parent or Guardian Signature_____ Date_____

Camper's Signature (If over 18) _____ Date_____

FOR OFFICE USE ONLY

Application Received: Date_____

Total Paid: $_____ Paid by: Cash Check
Check Number _____