DEEPER 8
Sound The Alarm
Youth & Young Adult Retreat
December 13-15, 2013
Riverside Campground

First Name_____ Last Name_____
Date of Birth: M__D__Yr____ Gender: F ( ) M ( )
Home Address _____
City _____ State_____ Zip Code _____
Phone_____ Email _____
Home Church _____

In case of emergency, please contact:
Name _____
Relation to Registrant _____
Immediate Phone # _____ Secondary Phone # _____

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Payment Information

Registration is not complete without full payment. Transportation / Walk-ins based on space availability.

Any application after October 13 must be accompanied with full payment of $90/person

( ) Check # ____ ( ) Cash ( ) Credit/Debit Card

Credit Card Number _____

Expiration Date __/____ Card Type (AmEx not accepted)_____ CVV # ____

Make checks payable to Love Fellowship Ministries and mail to:
P.O. Box 694206, Miami, FL 33269

Cancellation/Refund
No refunds will be issued after December 1st. Substitutions are allowed.

Applications are available for download at http://www.lfmcogop.org

Retreat Consent Form

I _____, agree to be responsible for my behavior, to respect the safety of others and myself. I understand that I am not to bring any electronic devices on this trip, including but not limited to media, telecommunication, and gaming devices. Leaders reserve the right to confiscate any of these items and return them prior to my going home at the end of the event.

Date_____ Retreaters Signature_____

In case of emergency, I understand that every effort will be made to contact me. If I cannot be reached, I hereby give the designated sponsor permission to act on my behalf to those administering treatment. I _____, hereby affirm and agree that I am the parent/guardian of a minor. I agree, on behalf of the minor named above to release and hold Love Fellowship Ministries Inc. harmless of any liability as a result of registrant's activities during this event.

Parent/ Guardian Name(s):_____ Signature_____

Any allergies or medical conditions_____
Any needed medication? Yes/No_____

Insurance Information:
Insurance Provider:_____ Account Number:_____
Primary Physician :_____ Primary Care #:_____