



**LUTHERIDGE**



**LUTHEROCK**



**LUTHERSPRINGS**



**LUTHERANCH**

**YOUTH REGISTRATION FORM**

Name of Program\*

\_\_\_\_\_

Dates\*

\_\_\_\_\_

Location\*

- Lutheridge (NC)
- Lutherock (NC)
- LutherSprings (FL)
- LutherRanch (GA)

Participant Name\* (Full Name)

Gender\* (M / F)    DOB\* (MM/DD/YYYY)    Grade\* (Currently-In or Just Completed)

\_\_\_\_\_

**Household Information**

Parent/Guardian Name\* (Full Name)

\_\_\_\_\_

Relation

\_\_\_\_\_

DOB\* (MM/DD/YYYY)

\_\_\_\_\_

Email Address\* (abc@123.com)

\_\_\_\_\_

Home Phone

\_\_\_\_\_

Cell Phone

\_\_\_\_\_

Parent/Guardian Name\* (Full Name)

\_\_\_\_\_

Relation

\_\_\_\_\_

DOB\* (MM/DD/YYYY)

\_\_\_\_\_

Email Address\* (abc@123.com)

\_\_\_\_\_

Home Phone

\_\_\_\_\_

Cell Phone

\_\_\_\_\_

Street Address\* (123 Somewhere St, Apt. 5)

\_\_\_\_\_

City, State Zip\* (City, ST 12345)

\_\_\_\_\_

Church Name (Where you attend)

\_\_\_\_\_

Church Location (City, State)

\_\_\_\_\_

**Emergency Contacts**

Name

\_\_\_\_\_

Relation

\_\_\_\_\_

Phone Number

\_\_\_\_\_

Name

\_\_\_\_\_

Relation

\_\_\_\_\_

Phone Number

\_\_\_\_\_

**Additional Information**

Roommate Request\* (Full Name)

Dietary Need / Food Allergies

Other Concerns (Mobility, Behavior, etc.)

Permission to Photograph \_\_\_\_\_ (Y/N)

*Photographs taken while at camp may be used in social media posts or in printed publications.*

Permission to Transport \_\_\_\_\_ (Y/N)

*Permission to transport camper off site for adventure activities or in the event of an emergency.*

**PERMISSION TO TREAT:** The Person this registration is for has permission to engage in all camp activities except as noted. I hereby give my permission to NovusWay Ministries to provide routine health care, administer prescribed medications and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for insurance purposes. I give permission for the camp to arrange necessary, related transportation for me/my child. In the event that I or the emergency contact cannot be reached in an emergency I hereby give permission to the Health Care Provider selected by the camp to secure and administer treatment, including hospitalization, for the person named in this form. This completed registration form may be printed/copied for trips off camp.

Parent/Guardian Signature

Date

### Billing Information

Select your payment method below. (Deposits are due at the time of registration)

#### Personal Billing Information

I plan to pay camp fees \_\_\_\_\_ (Y/N)

Total Amount (Dollar amount to be charged today)

Name on the Card

Card Number

Expiration (MM/YY)

CVC (123)

Signature\* (You agree to be charged the above amount)

#### Church Billing Information

Bill my church for camp fees \_\_\_\_\_ (Y/N)

Total Amount (Dollar amount to be billed to church)

Church Name

Street Address

City,State

Zip

For More Information Contact The Registration Office at: 828-209-6301, [registration@novusway.org](mailto:registration@novusway.org)  
2049 Upper Laurel Drive, Arden NC 28704