Our mission at LJCC is to create experiences that inspire and prepare the next generation to be followers of Jesus.

JUNIOR FACULTY TRAINING RETREAT

FRIDAY AND SATURDAY APRIL 11 & 12, 2025

FRIDAY CHECK-IN FROM 6-6:30PM **RETREAT CONCLUDES SATURDAY AT 4:00PM**

Registration form & money to be postmarked by Saturday, April 1, 2025 ($25.00).
Late registrations postmarked or hand delivered after Saturday, April 1, 2025 ($40.00).

- You may use this paper form to register or you may register online at www.ljca.org
- If registering by paper, send this form along with the registration fee to:

LAKE JAMES CHRISTIAN ASSEMBLY, 1880 W 275 N, ANGOLA, IN 46703

- All applicants must have their church minister or youth minister complete a recommendation. This is done online via the QR code below or online (just share with your minister or youth minister).

SCAN ME!

Name: _____ Birth Date: ____/____/____ Current Grade:____ Gender: ____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Email Address: _____
Church Name: _____
Do you plan to help as Jr. Faculty for Horse Camps? Yes ____ No ____
Have you been baptized by immersion? _____ *(Answering "no" to this question does not disqualify you from attending this training retreat. Although we prefer that our camp Deans enlist faculty who are immersed believers in Jesus Christ, a camp Dean could choose to use you as a Junior Faculty member based on a variety of positive qualities that would benefit a session of camp.)*

In Case of Emergency I hereby give my permission to LJCC to hospitalize, secure treatment for and to order anesthesia or surgery for my child named above. I understand that every effort will be made to contact me in case of such emergency, if possible, before such treatment is administered. I hereby release the camp from any responsibility other than normal supervision and care. In case of accident I will not hold Lake James Christian Camp and Retreat Center or its staff, management or officers liable unless guilty of negligence. **I understand that camp insurance is secondary.**

Signature of Teenager attending the Retreat: _____ Date: ____/____/____

*Printed Name of Parent or Guardian: _____
*Signature of Parent or Guardian: _____ Date: ____/____/____

Emergency Contact Name: _____ Emergency Contact Phone #: _____

Year of last Tetanus Booster: _____ My child is current on all immunizations: Yes____ No____

Please list any food, medication, insect, or other allergies (you don't need to include seasonal allergies) and describe the reaction and management of the reaction.
Allergies to Foods: _____ Severity of Reaction: _____
Management/Treatment: _____
Other Allergies: _____ Severity of Reaction: _____
Management/Treatment: _____
Medical condition(s) or history and special health/behavioral/physical considerations or limitations. Nothing marked indicated the applicant has no medical conditions and is capable of full participation.

Medical Cond. _____ Explained: _____
Recent surgery, injury or permanent conditions that may restrict the applicant's activities: _____
Optional: Any recent life changes? (death, divorce, homesickness, etc.?): _____

These over-the-counter medications are stocked at LJCC, used to help manage common illness or injury, and dispensed by standing orders signed by LJCC's supervising physician. Some meds are listed as common brand names, though generic may be substituted. Acetaminophen, aloe vera, ibuprofen, antacid (Tums & Mylanta), antifungal spray, burn gel, Zyrtec, Benadryl (oral & ointment), Epi-Pen (used for anaphylactic reaction), hydrocortisone cream, Lanacaine 1st aid spray, Immodium Ad, Gold Bond medicated power, Midol, pain relief/ointment (Bengay/Biofreeze), Milk of Magnesia, Miralax, Nix, Sudafed, swimmer's ear drops, throat lozenges, tussin, tussin DM, triple antibiotic ointment, bacitracin ointment, Calamine lotion, orajel, sunscreen, docusate sodium (stool softener), Visine AC.
Please list any medication(s) you DO NOT want your child to have: _____
Current prescriptions/Nonprescription Drugs or Meds: _____
Family Physician Name: _____ Physician Phone: _____
Health Insurance Company: _____ ID #: _____ Group#: _____
Insured's Name: _____ Insured's DOB: ____/____/____
Alternate Contact: _____ Phone: ____/____/____
Relationship with alternate contact person: _____