

WLS Registration

June 29 - July 4, 2020

SPACE IS LIMITED, REGISTER TODAY!

We anticipate a high volume of WLS attendees - to secure your spot, please register as early as possible. WLS is for ages 15-30. Thank you.

DEADLINE & PRICE: BEFORE June 1 = \$30 AFTER June 1 (including On Site) = \$40

Please do not mail paperwork or payment after June 15, 2020.

ON EAGLES' WINGS®



WARRIOR LEADERSHIP SUMMIT

Name: _____ Address: _____

City/State/Zip: _____

Phone: _____ Email: _____

Current age: _____ Birth date: Month _____ Day _____ Year _____ Circle one: male female

Reservation / Reserve: _____ Tribe / Nation: _____

(WLS is for Native American and First Nations young people)

How are you getting to Warrior Leadership Summit? Travel on own Travel with group

If you are coming with a group, who is your group leader?

Group leader name: _____ Phone number: _____

Please send an On Eagles' Wings® TEAM application (Summer of Hope).

In the event of an emergency, we will contact your Emergency Contact #1 first. Please provide one additional emergency contact.

Emergency Contact #1

Name: _____ Relationship to you: _____

Home phone: _____ Work phone: _____ Cell phone: _____

Emergency Contact #2

Name: _____ Relationship to you: _____

Home phone: _____ Work phone: _____ Cell phone: _____

To be FULLY REGISTERED, please send -

- This completed and signed Registration Form (if under 18, this must be signed by a parent)
- The Medical Release Form (if under 18, this must be signed by a parent)
- Registration Fees **To pay by credit card call us @ 870-741-3300**

**Send To:
On Eagles' Wings®**

P.O. Box 400 Harrison, AR 72602
or Fax to: 870-741-3400

In consideration of Ron Hutchcraft Ministries, Inc. (RHM) allowing me to participate in Warrior Leadership Summit on the following dates: June 29, 2020 through July 4, 2020, and if selected for On Eagles' Wings Summer of Hope 2020, from July 4, 2020 through August 5, 2020, (collectively, the "Programs"). I hereby agree to hold Ron Hutchcraft Ministries, Inc., its staff, agents, employees, licensees and assigns harmless from any personal liability arising from personal injury or loss of property.

I further grant to Ron Hutchcraft Ministries, Inc., its successors and assigns, the right to use my name and likeness and publish photographs and video of myself for training materials, editorial, advertising and any other purpose in connection with the Programs in any and all manner and media throughout the world in perpetuity. I expressly release RHM, its agents, employees, licensees and assigns from and against any and all claims which I have or may have for invasion of privacy, defamation or any other cause of action arising out of production, distribution, broadcast or exhibition of such photographs and video.

I further state that I HAVE CAREFULLY READ THIS RELEASE AND KNOW THE CONTENTS CONTAINED AND I SIGN THIS RELEASE AS MY OWN FREE ACT.

Name (please print): _____ Signature (if over 18 years old): _____

*** IF ATTENDEE IS 18 YEARS OR OLDER, THE ATTENDEE CAN SIGN ABOVE.

IF ATTENDEE IS UNDER 18 YEARS OLD, A PARENT/LEGAL GUARDIAN MUST SIGN BELOW.***

Parent/Legal Guardian Name: _____ Primary phone: _____
(please print)

Parent/Legal Guardian Signature: _____ Date: _____ Secondary phone: _____

MEDICAL RELEASE FORM

By completing the attached medical release form, I hereby authorize Ron Hutchcraft Ministries, Inc. or any other designated adult personnel to obtain medical treatment for my (son/daughter) in the case of illness or injury. This agreement includes prescription medication as well as over-the-counter medications. I understand that Ron Hutchcraft Ministries, Inc., staff, representatives, or any other associated personnel shall not be held liable for any medical costs arising from treatment of my (son/daughter).

I hereby agree to hold Ron Hutchcraft Ministries, Inc., staff, representatives or any other associated personnel, harmless from any personal liability to my (son/daughter) arising from personal injury or loss of property.

I further state that I HAVE CAREFULLY READ THIS RELEASE AND KNOW THE CONTENTS CONTAINED AND I SIGN THIS RELEASE AS MY OWN FREE ACT. (Use back of this page if more space is needed.)

Information provided on this form will be kept in confidence and available only to staff personnel who may need it to get treatment for the attendee.

Patient's Name: _____ Sex: M / F Date of Birth: _____

Name of Health Insurance Company or IHS: _____ Policy #: _____

Family Doctor: _____ Dr.'s Phone #: _____

Dr.'s Address: _____

Medical History: _____

Allergies to Medication: _____ Approximate date of last tetanus shot: _____

Other Allergies (food, environment, etc.): _____

Any known tendency to (circle all that apply): *Asthma Diabetes Epileptic Convulsions Hay Fever Seizures High Blood Pressure Other* _____

Recent illnesses or accidents, dates and current status: _____

Will you need any prescription medication(s)? Yes No Name of medication(s): _____

****NOTE: ALL PRESCRIPTION MEDICATION MUST BE IN ORIGINAL PACKAGING (bottle, etc.). NURSE MUST BE SHOWN ALL PRESCRIPTION MEDICATION IMMEDIATELY UPON ARRIVAL TO VERIFY. IF 18 OR YOUNGER, ALL PRESCRIPTION MEDICATION WILL BE CHECKED IN AND DISPERSED BY THE HEALTH CARE TECHNICIANS.**

Any other health issues we should be aware of? _____

Attendee's Name (Print): _____ Attendee's Signature: _____

*****IF ATTENDEE IS UNDER 18 YEARS OLD, A PARENT/LEGAL GUARDIAN MUST SIGN. IF ATTENDEE IS 18 YEARS OR OLDER, THE ATTENDEE CAN SIGN.**

Parent/Guardian (Print): _____ Parent/Guardian Signature: _____

Date: _____ Emergency Phone #: _____

Please make sure that your (son/daughter) has the necessary paperwork or card for IHS or other health insurance coverage while attending Warrior Leadership Summit and/or On Eagles' Wings® "Summer of Hope".