WORKER

The Way to Antioch
Worker Application

PLEASE PRINT CLEARY –
ONE APPLICATION PER PERSON

**NOTE: This is only an application. Notification of your assigned weekend will be made by mail or by e-mail. After you have completed your part of this application, please e-mail to thewaytoantioch@gmail.com or mail to 1632 Murl Road, Monticello KY 42633. All information will be kept confidential. Incomplete applications will be returned. Placement will be made based upon date received, availability of space and discretion of the Antioch Board. Please list an address and number where you can be reached.

INFORMATION

FullName:_____ Mailing

Address:_____City:_____St: _____ Zip: _____ Phone: (____)

_____ Date of Birth: _____ Marital Status: _____

E-mail _____ Gender: Male ☐ Female ☐

Your Occupation _____

Your Church _____ Member ☐ Visiting ☐

Pastor's Name _____

***If applicable:* SpouseName_____Spouse Cell # (____) _____

Please circle the area you would like to serve in ☐ Kitchen, ☐ Logistics, ☐ Prayer Chapel, ☐ Conference room ☐ Music Team

RETREAT SERVICE OPTIONS: To work The Way to Antioch it cost $130 per worker.

☐ **Youth Retreat** ☐ **Men's Retreat** ☐ **Women's Retreat** ☐ **Spring** ☐ **Fall**

Check either Youth Retreat, Men's or Women's Retreat. Then, check Spring or Fall.

Previous Experience

1.) Have you ever worked a retreat like this before?_____
_____

2.) Where have you worked before? Conference Room, behind the scenes, etc.?_____
_____

3) You will need to attend 2-5 team meetings prior to the retreat. Will you be committed to attending these meetings_____

Worker's Signature

_____

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Medical Release Form

(must haveparent/guardiansignatureifnot 18+)

Name:_____**DOB**:_____

Address:_____

Parent/Guardian:_____ **Phone Number:** _____

Medical Insurance Carrier: _____**ID#**_____

PMH__Diabetes__(Insulin?__)Seizures__(Diastat?__)Asthma__(Emergency Inhaler?__)Heart Issues__ (NTG?__)

Medications used:_____ **Drug Allergies**:_____

Food Allergies or special dietary needs:_____

Environmental Allergies:_____ **Epi Pen**?_____

Emergency Contact:_____ **Relationship**:_____

Phone Number:_____ **Alternate Number**:_____

Pertinent Information/Significant Medical History /Physical limitations or restrictions: _____

In case of an accident or other emergency, I herby grant the Mt. View Baptist Camp Superintendent permission to authorize medical attention by a physician or hospital as necessary.

Pursuant to the provisions of the civil code of the State of Kentucky, I the undersigned, do hereby authorize as agents, the Board of Directors of The Way to Antioch supervisors to consent to any treatment or hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of any physician/surgeon licensed under the provision of the medical Practice Act, or by a dentist licensed under the provision of the Dental Practice Act. It is understood that this authorization is given in advance of any specific care required, but is given to provide authority to give care which any physician may, in the exercise of his/her best judgment, deem advisable.

I further authorize that any of the above-named agents that have active status as Emergency Medical Technicians, may perform care up to the level in which they are allowed, if deemed necessary by them.

I also allow any hospital or medical facility which has provided treatment, to surrender physical custody to my above-named agents upon completion of treatment. This authorization is given pursuant to the Health and Safety Code.

I do hereby release The Way to Antioch Board of Directors and/or its designee from liability in case of accident. This authorization shall remain in effect until revoked in writing and delivered to the said agent.

Participant Signature: _____ **Date:**_____

Parent/Guardian Signature: _____ **Date:**_____

***If under 18, this form must have a parent/guardian signature.**