

**Roc SALT**  
***Rochester Serving and Learning Together***  
68 Ashland Street  
Rochester NY 14620

**Adult Registration Form**

Name \_\_\_\_\_

Pronoun \_\_\_\_\_ Nickname \_\_\_\_\_

Church affiliation \_\_\_\_\_

Address (home)

Mission Dates \_\_\_\_\_

**Emergency Contact Information**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone number: \_\_\_\_\_

Allergies \_\_\_\_\_

If yes reactions/recommended interventions

Do you have any special concerns we should be aware of?

**Media Release and Permission Form**

**Participant Name** \_\_\_\_\_

**I realize that pictures and video of me may be used (without names) on ROC SALT, Presbytery and partner organization websites and social media pages, along with printed marketing materials, presbytery/church newsletters and other publicity materials for the purpose of sharing the activities and promoting ROC SALT's mission work. I hereby give permission for my image to be included in such postings and materials.**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

All mission participants must also submit two mandatory forms (attached)

\_\_\_\_ Medical Form

\_\_\_\_ FoodLink volunteer registration (if applicable)

**ROC SALT Mission Center  
Medical Form**

Name \_\_\_\_\_

Birth Date \_\_\_\_\_ Email Address \_\_\_\_\_

Address \_\_\_\_\_  
(Include street or box number, street, city, and zip code.)

Phone Number \_\_\_\_\_ Cell Phone Number \_\_\_\_\_

Work Place \_\_\_\_\_

Work Place Phone Number \_\_\_\_\_

Primary Physician \_\_\_\_\_ Phone \_\_\_\_\_

Dentist \_\_\_\_\_ Phone \_\_\_\_\_

Special Medical Conditions

Date of last tetanus shot \_\_\_\_\_

Ongoing medications \_\_\_\_\_

Allergies (medicine, food, insects etc.)

Health Insurance Company \_\_\_\_\_

Policy Number \_\_\_\_\_

Does your insurance company require a second opinion before emergency procedures can be undertaken? \_\_\_\_\_ Yes \_\_\_\_\_ No

\*Please provide a copy of the insurance card.

Other information that you would like us to know:

**Emergency Contact Information**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_

(Include street or box number, street, city, and zip code.)

Home Phone Number \_\_\_\_\_ Work Place Phone Number \_\_\_\_\_

Cell Phone Number \_\_\_\_\_ E-mail \_\_\_\_\_

**Authorization**

I (print name) \_\_\_\_\_ understand that participation in ROC SALT's mission programs may involve physical and recreational activity, and I understand that every effort will be made to ensure the health and safety of all participants. In the event of an emergency, I authorize calling a physician at my expense to provide whatever medical or surgical care is necessary. I agree to indemnify and hold harmless ROC SALT Mission Center, the Presbytery of Genesee Valley and their partner service organizations, their officers, agents, volunteers and employees from any and all claims, loss, cost, damage or expense arising out of or from any accident or other occurrence, causing injury to any person or property. I understand that this authorization covers both events on and off of ROC SALT Mission Center grounds as well as work with partner organizations.

Signature \_\_\_\_\_ Date \_\_\_\_\_