



Individual Participant Registration Form for Youth and Adults

NOVEMBER 20-21, 2026

NO BACKPACKS ALLOWED

www.epsync.org

Parish Name: _____ Group Name: _____

☐ \$25 Registration Fee Make all payments payable to St. Joseph Catholic Church Memo: El Paso Southwest Youth Conference

Last Name: _____ First Name: _____

Date of Birth ____/____/____ Current Grade: _____ Youth Participants must be in 8th grade **OR** be 13 years old

Gender: Male Female Email Address: _____

Mailing Address: _____
Street City State Zip Code

NOTE: With the exception of Group Leaders, ALL cell phones MUST be turned OFF at all times during conference activities. If you are expecting a call, please let one of the hospitality or staff members know at time of registration or before conference activities. Out of respect for all participants and presenters, if a staff member sees a participant using a cell phone, iPod/iPad, etc., it will be confiscated and their Group Leader may pick it up at the end of the day.

Parent/Guardian/Conservator's Name: _____

Mailing Address: _____
Street City State Zip Code

Phone Number: Home# (____) _____ Cell# (____) _____

Emergency Contact Name: _____

Relationship to the participant named above: _____

Phone Number: Home# (____) _____ Cell# (____) _____

Release/Indemnification Information:

_____ Has my permission as his/her Parent/Guardian/Conservator to participate in the El Paso Southwest Youth Conference. I understand that as parent/guardian/conservator, I remain legally responsible for any personal actions taken by the participant named above. I agree on behalf of myself, my son/daughter/participant named herein, our/his/her heirs, successors, and assign to hold harmless, the Diocese of El Paso, St. Joseph Catholic Church, Region 19, Starlight Event Center, and its representatives, the El Paso Southwest Youth Conference organizers and volunteers, and/or the Parish of _____, and its/their employees and/or volunteers from any and all claims (unless due in part by gross negligence) for illness, injury, death and the cost of medical treatment therewith, arising from or in any way connected with son/daughter/participant's attending the various programs and activities during the dates named above. In the event any legal action is taken by either party against to other party to enforce any of the terms and conditions of this agreement, it is agreed that the unsuccessful party to such action shall pay to the prevailing party therein all reasonable court costs, reasonable attorney's fees and expenses incurred by the prevailing party.

Promotional Release:

I also consent to the user of any videotapes, photographs, slides, audiotapes, or any other visual or audio reproduction (In perpetuity unless otherwise revoked by me in writing and delivered by certified mail, return requested, to: El Paso Southwest Youth Conference, 9024 El Dorado, El Paso, TX, 79925) in which my son/daughter/participant may appear by the El Paso Southwest Youth Conference. I understand that these materials are being used for promotion of the El Paso Southwest Youth Conference which may include recruitment and fundraising efforts.

Signature: X _____ Date: _____

Participant Medical Information: I understand all reasonable safety precautions will be taken at all time by the Youth Ministers/ Chaperones/EPSYC Staff and its agents and that in the event that medical intervention is necessary, every attempt will be made to contact, immediately, the persons listed on this form. If I cannot be reached in an emergency, I give my permission to the EPSYC leadership to hospitalize, to secure medical treatment and order an injection, anesthesia, or surgery for my child as deemed necessary. I understand the possibility of unforeseen hazards and know there is the inherent possibility or risk. I agree not to hold the EPSYC Staff, its leaders, employees, and volunteers liable for damages, losses, diseases or injuries incurred by the subject of this form.

Youth Participant’s Name: _____

Insurance Carrier: _____ Policy Number: _____

Insurance ID Number: _____ Family Physician Number: _____

Medications: (Check all that apply— **Note: DO NOT CHECK ALL BOXES AS ONE MAY CANCEL OUT ANOTHER**)

☐ This child takes no medication and will bring no medication with him/her.

☐ This child takes medication (s) and will self– medicate. The child’s parent/guardian/conservator will provide and dispense any and all needed medications necessary, and such medication will be clearly labeled, I understand that the child will be required to turn all medications, exact dosage and frequencies /time over to their group’s leadership and that it will be this child’s responsibility to present himself/herself to their group’s designee at the time required to take their medication (s) at the frequencies /times necessary. I understand that the adult to whom this child surrenders the medication has no medical training and this adult will NOT measure dosages. This child will return the medication (s) to the adult after he/she self-medicates. At the conclusion of the event, it will be this child’s responsibility to pick up the remaining medication (s).

☐ This child takes medication but is unable to self-medicate. The child’s parent/guardian/conservator will provide and dispense any and all needed medications.

☐ No medication of any type whether prescription or non-prescription may be administered to this child unless the situation if life-threatening and emergency treatment is required.

I grant my permission for the following non-prescription medication to be given to this child

Non-aspirin pain reliever:	No _____	Yes _____	# of tablets per dosage _____
Decongestant:	No _____	Yes _____	# of tablets per dosage _____
Antihistamine:	No _____	Yes _____	# of tablets per dosage _____
Throat Lozenges:	No _____	Yes _____	# of tablets per dosage _____
Antacid:	No _____	Yes _____	# of tablets per dosage _____

Specific Medical Information:

Allergic reactions (medications, food, plants, insects, etc.) _____

Immunization– Date of last tetanus/diphtheria immunization: _____

Other medications child currently takes: _____

Any physical limitations: _____

Has participant recently been exposed to contagious disease or conditions such as mumps, measles, chicken pox, etc.? If so, date and disease or condition: _____

You should also be aware of this participant’s special medical conditions: _____

Signature: X _____ Date: _____