

# FAITHS

## (Friends Acting In The Holy Spirit)

### June 23-27, 2008

My friends, what good is it to say you have faith,  
if you don't do anything to show that you have faith?

James 2:14

FAITHS is a summer mission day camp for students entering 7th-12th grade. We will use each day to work on service projects in the Iowa City area, and to serve a lunch to grandparent-age members of our congregation. Our days will begin at 8:30 a.m. with devotions and directions. Our work will end between noon and 2 p.m., depending on the project for the day.

NAME: \_\_\_\_\_

GRADE IN FALL 2008: \_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_

E-MAIL: \_\_\_\_\_

T-Shirt size: YM YL AS AM AL AXL

COST to participate in FAITHS is \$10 (to cover the cost of the shirt)

Please list a few projects (type of work, location, etc.) you would like to work on this year  
(The first few students to sign up will get to help choose the activities for the week):

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Past projects have included painting a park shelter, sorting food and gardening at the Iowa City Food Bank, painting award stands for Special Olympics, picking up trash, preparing a meal for the Ronald McDonald House, and working with children.

For more information: [heatherw@saintandrew-ic.org](mailto:heatherw@saintandrew-ic.org) or call the church office, 338-7523

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## Saint Andrew Presbyterian Church

I, the parent or guardian of \_\_\_\_\_, give permission for my child to participate in mission projects at Saint Andrew Presbyterian Church. I understand that my child will be transported to several sites during the week. I give permission for project leaders to secure emergency medical treatment for my child from a licensed physician and/or hospital. I understand that every effort will be made to contact me (or those whom I designate as emergency contacts) in an emergency in order that they or I may make decisions regarding the nature and place of emergency treatment.

\_\_\_\_\_  
Student's name \_\_\_\_\_  
Birthday

\_\_\_\_\_  
Street Address \_\_\_\_\_  
City \_\_\_\_\_  
ZIP Code

\_\_\_\_\_  
Mother's Name \_\_\_\_\_  
Home phone \_\_\_\_\_  
Work phone

\_\_\_\_\_  
Father's Name \_\_\_\_\_  
Home phone \_\_\_\_\_  
Work phone

\_\_\_\_\_  
Doctor's Name \_\_\_\_\_  
Doctor's phone

\_\_\_\_\_  
Insurance Company \_\_\_\_\_  
Policy Number

Emergency contact in case neither parent can be reached:

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

Is your child epileptic? NO YES  
Is your child diabetic? NO YES  
Is your child allergic to medications? NO YES (please list) \_\_\_\_\_  
Does your child have other known allergies? NO YES (please list) \_\_\_\_\_  
Is your child currently taking medications? NO YES (please list) \_\_\_\_\_

Parent/guardian signature \_\_\_\_\_

Today's date: \_\_\_\_\_