Ogallala Quilters' Society
Winter Retreat Registration Form
January 23 - 26, 2025

Please Print Clearly

Full Name	
Address	
City, State, Zip	
Phone Number	
Email address	

Please list names of 3 roommates *(4 will be assigned to a room)*	1.
	2.
	3.

Snacks! The most important part of Retreat!

Please bring a snack to share throughout the weekend!

If your last name begins with:

A thru J – bring a sweet snack

K thru Z –un-sweet snack

Also bring a breakfast item to share with the group ______________________.

Please list if you smoke or have an allergy, we need to be aware of ________________________.

Please let me know if you prefer to sleep warmer or cooler ___________________________

Retreat Costs

¨	4 Day Retreat – Thursday through Sunday	$325
	Membership Fee (add because it is the beginning of a new year) 2025	$25
¨	Total amount due:	$350

Please enter the TOTAL AMOUNT enclosed with this form.	
Total	**$**

Will you be attending Sunday lunch: Yes, _____ or no, ______

Let me know if you want to help with lunch on Sunday __________________.

Let me know if you would be willing to help with setting up or tearing down ______________________

If you cancel before January 8th, there will be a non-refundable fee of $25.
If you cancel after January 8th, there will be no refund.

Signature ____ Date___________________

Please mail this Registration Form and the Medical Release form along with your check to: Tana Frazier 3600 Woodhaven Court Midland TX 79707

Make your check payable to: Ogallala Quilters' Society

Ogallala Quilters' Society
Winter Retreat Medical Release Form

We are aware of the Patient Privacy Act and understand if you choose not to disclose this information. However, we want to make sure you are taken care of correctly if the need arises. This form is filed and used for emergency purposes only.	
I, ______________________________ release Ceta Canyon and the Ogallala Quilters' Society of any responsibility for accidents that occur while visiting the facilities. I do release medical information inquired below in case of accident and if it is needed for those purposes.	
In case of emergency:	
Please contact:	Phone:
Name of Family Physician:	Phone:
Preferred Hospital	
Do you have any allergies or medical conditions we need to be aware of?	
List any medications you might be taking at this time:	

Signature ______________________________________ Date____________________

(Your signature is required)