YOUTH PERMISSION FORM

GLORY REALIZED RETREAT – March 10-12, 2017
CampMayMac – Felton, CA
$150.00 PER PERSON

INCLUDES: 2-NIGHTS LODGING, 6 MEALS, SNACKS, T-SHIRT & AN AWESOME EXPERIENCE.
SCHOLARSHIPS OR PAYMENT PLANS ARE AVAILABLE UPON REQUEST.
CHECKS MADE PAYABLE TO ***HOLY SPIRIT CHURCH***
PLEASE CONTACT THE YOUTH MINISTRY OFFICE FOR DETAILS: 408.997.5106

****PERMISSION FORMS ARE DUE BY FEBRUARY 27TH ****

PARENTS: A NEWSLETTER WILL BE SENT OUT VIA EMAIL. ALL DETAILS REGARDING THE RETREAT WILL BE IN THE NEWSLETTER

PARTICIPANT GENERAL INFORMATION (PLEASE PRINT)

FIRST & LAST NAME: _____ DOB: _____ M/F: _____

ADDRESS:_____ CITY:_____ ZIP:_____

PHONE#: _____ EMAIL: _____

SCHOOL: _____ GRADE: _____

PLEASE SELECT SHIRT SIZE: ☐ S ☐ M ☐ L ☐ XL ☐ XXL OTHER: _____
(Adult unisex size)

PARENT AND EMERGENCY INFORMATION

PARENT/ GUARDIAN: _____ CELL#: _____

EMAIL: _____

PERSON TO NOTIFY IN CASE OF EMERGENCY (OTHER THAN PARENT):

CONTACT: _____ PHONE#: _____ RELATIONSHIP: _____

PARTICIPANT MEDICAL INFORMATION

FOR HEALTH AND SAFETY REASONS, PLEASE ANSWER THE FOLLOWING QUESTIONS. ANY "YES" RESPONSE WILL REQUIRE AN EXPLANATION.

WILL YOU BE BRINGING ANY TYPE OF MEDICATION TO THIS EVENT? ☐ YES ☐ NO

IF YES, PLEASE PROVIDE DETAILS AND INSTRUCTIONS: _____

_____

PLEASE COMPLETE THE OTHER SIDE

DO YOU HAVE ANY TYPES OF ALLERGIES (FOOD OR SEASONAL)? ☐ YES ☐ NO

PLEASE SPECIFY: _____

ARE YOU A VEGETARIAN? ☐ YES ☐ NO

DESCRIBE ANY OTHER SPECIAL NEEDS WE SHOULD BE AWARE OF:

_____

I HAVE THE FOLLOWING MEDICAL INSURANCE THAT WOULD COVER ANY HOSPITAL, MEDICAL AND RELATED COSTS AND EXPENSES IN THE EVENT OF ILLNESS OR ACCIDENT OF AN EMERGENCY NATURE:

DOCTOR'S NAME: _____ PHONE #: _____

POLICY NAME: _____ POLICY #: _____

IN THE EVENT MY CHILD IS INJURED OR BECOME ILL AND REQUIRES EMERGENCY MEDICAL ATTENTION, ANY RESULTING HOSPITAL, MEDICAL, OR RELATED COSTS AND EXPENSES WILL FIRST BE PAID BY THE MEDICAL INSURANCE OR BENEFIT PLAN OF MINE OR MY SPOUSE. I AM NOT AWARE OF ANY MEDICAL CONDITION OF MY CHILD, WHICH WOULD RENDER IT INAPPROPRIATE FOR HIM/HER TO PARTICIPATE IN ANY SUCH ACTIVITY.

I HEREBY GIVE PERMISSION TO THE PHYSICIAN SELECTED BY THE YOUTH ACTIVITIES SUPERVISORY PERSONNEL THEN PRESENT TO RENDER MEDICAL TREATMENT DEEMED NECESSARY AND APPROPRIATE BY THE PHYSICIAN. IF THE PHYSICIAN/DENTIST CANNOT BE REACHED, THEY MAY MAKE THE NECESSARY ARRANGEMENTS TO SEEK MEDICAL CARE.

CONDUCT AND DISCIPLINARY AGREEMENT

FOR PARENT/GUARDIAN:

I, THE PARENT (GUARDIAN) OF THE ABOVE NAMES CHILD, HEREBY, GIVE PERMISSION FOR HIS/HER PARTICIPATION IN THE ACTIVITY NAMED ABOVE. I AGREE TO DIRECT MY CHILD TO COOPERATE WITH THE DIRECTIONS AND INSTRUCTIONS OF THE PARISH, SCHOOL OF DIOCESAN PERSONNEL RESPONSIBLE FOR THE ACTIVITY. NOTE: SHOULD MY CHILD CHOOSE NOT TO FOLLOW THE GUIDELINES AND EXPECTATIONS FOR THIS RETREAT, **I UNDERSTAND THAT THERE WILL BE CONSEQUENCES FOR THEIR ACTIONS, INCLUDING BEING REMOVED FROM THE ACTIVITY AND/OR BEING SENT HOME. IF MY CHILD IS SENT HOME, I AGREE TO MAKE ARRANGEMENTS TO HAVE MY CHILD PICKED UP IMMEDIATELY.**

_____ _____

PARENT/GUARDIAN'S SIGNATURE: DATE

FOR PARTICIPANT:

IN SIGNING BELOW, I AGREE TO ABIDE BY ALL RULES ESTABLISHED AT THIS EVENT. SHOULD I CHOOSE NOT TO FOLLOW THE GUIDELINES AND EXPECTATIONS OF THE ADULTS AND MY PEERS, **I UNDERSTAND THAT THERE WILL BE CONSEQUENCES FOR MY BEHAVIOR, INCLUDING BEING REMOVED FROM THE ACTIVITY AND/OR BEING SENT HOME AT MY PARENT'S EXPENSE**.

_____ _____

PARTICIPANT'S SIGNATURE: DATE