

St. Elizabeth of Hungary Parish
Confirmation Preparation Program 2008 - 2009
Weekend Confirmation Retreat
November 29th – November 30th

Mellos Retreat Center, Jacksonville, VT

Cost - \$75.00

Please have this form and payment returned by November 14th

Parent/Guardian Release and Consent Form

This form must be turned in to the Youth Ministry Office at the Parish Center no later November 14th. We cannot allow anyone to participate in this event without the release form.

Name of Youth: _____ Phone: _____

Address: _____ Town: _____

Youth's E-mail: _____ Graduation Year: _____

In case of an emergency, please notify: _____
(Name & Phone)

Are there any limitations to the activities in which your child can participate?

Yes _____ No _____ If yes, please explain _____

I, _____, give permission for my son/daughter _____ to participate on the (name of event) _____. I give permission for my daughter/son to be transported in privately owned and/or public vehicles/public transportation to and from St. Elizabeth of Hungary Parish to and from the event. I understand that the group may stop on the way for something to eat.

In case of medical emergency, I understand that every effort will be made to contact the parent(s) or guardian(s) of my child. In the event that I cannot be reached, I give permission for my son/daughter to be evaluated, diagnosed, treated and/or medicated by licensed medical personal. In addition, I give permission for the release of any medical records that I provided to St. Elizabeth of Hungary Parish to medical personnel.

I hereby release the Roman Catholic Archbishop of Boston, a Corporation Sole, its agents, servants and employees and all priests incardinated to the Roman Catholic Archdiocese of Boston, St. Elizabeth of Hungary Parish staff and/or volunteers that work with youth ministry, from any and all liabilities for personal property incident to this event and any aforementioned medical care and treatment which is provided.

I have read the foregoing and understand the same.

Parent/Guardian Signature: _____ Date: _____

Medical Information

Name of Participant: _____ Date of Birth: _____
Address: _____ Male: _____ Female: _____
City: _____ Zip: _____ Phone: _____

IN CASE OF AN EMERGENCY, please notify: _____
PHONE: Day: _____ Evening: _____ Cell: _____
Relationship to participant: _____

EMERGENCY INFORMATION: Family Physician or Clinic:

Name: _____ Emergency Phone: _____
Address: _____ City: _____ State: _____ Zip: _____
Insurance Company: _____
Policy Carrier: _____ Policy Number: _____

*******MUST ENCLOSE A COPY OF MEDICAL CARD*******

Is there anything about your child's health that we should be aware of such as:

_____ Diabetes _____ Fainting Trouble _____ Seizure Activity
_____ Heart Problems _____ Migraines _____ Bleeding Disorders
_____ Asthma _____ Severe Allergic Reactions (Bee Sting/Food/other)
_____ Other health issues we should be made aware of _____

If any of the above is checked, please submit a statement of how the person has been treated and with what medication(s) – (eppi pen, inhaler, insulin shots, pills, etc.)

My child **is or may be** allergic to (food, insect bites, medications, pollen, nuts, etc.):

My child must take the following medications: (please indicate dosage, frequency, reason for medication etc.) _____

PLEASE BE ADVISED, ADULTS CANNOT DISPENSE ANY MEDICATION

Immunization History: Please give dates of last shots:

Tetanus: _____ MMR: _____

Signature of Parent/Guardian: _____ Date: _____