FALL 2011 HIGH SCHOOL RETREAT
STUDENT PERMISSION FORM & MEDICAL RELEASE

I hereby give permission for my child/ward _____ to attend and participate in the High School Retreat held **Friday, November 18, 2011 through Sunday, November 20, 2011** at Dickson Valley Christian Retreat Center in Newark, IL. I hereby release and indemnify St. Peter Church, its staff and volunteers, and the Catholic Bishop and Diocese of Rockford from any and all demands, claims, or liability of any nature whatsoever from my child's participation in this event. I agree that my child will abide by our rules and those of St. Peter Youth Ministry. If my child does not abide by those rules, I agree to be responsible for my child's actions and agree to provide transportation home from this event should the need arise.

_____ _____
SIGNATURE of Parent/Guardian Date

_____ _____
Address City/State/Zip

Registration opens for this retreat opens MONDAY, AUGUST 22, 2011 (do not submit form prior to that date). By signing this form, parents affirm to have read and accept the retreat registration policies detailed in the Confirmation Parent Handbook.

MEDICAL PERMISSION FORM

I grant permission for the administration of first aide to my child (named above) by the people in charge of the program and those transporting my child to and from the program as their judgement deems advisable and to make the necessary referrals to qualified physicians for treatment of illness or accidents of a more serious nature. I understand I will be responsible for any medical expenses incurred. I understand that I will be promptly notified in the event of any serious illness or accident and prior to any major surgery, except when delay in such communication would endanger life. In case of medical emergency, I understand that every effort will be made to contact the parents/guardians of the participant. In the event that I cannot be reached I hereby give permission to the physician selected by the adult staff to hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery if deemed necessary for my child/ward.

_____ _____
SIGNATURE of Parent/Guardian Date

_____ _____
Home Phone Number Numbers where you can be reached during the event

_____ _____
Authorized Physician Physician's Phone Number

Child's Age_____ Birthday___/___/___ Height_____ Weight_____ T-Shirt Size _____

Please List any Medical Conditions/Allergies that we should be aware of in addition to any current medications:

INSURANCE INFORMATION

_____ _____
Insurance Company Insurance Customer Service/Benefits Phone

_____
Policy Holder

_____
Policy Number

PARENTS: WE MAY NEED HELP!

Prayerfully consider if you can help us.
We will call you if we need your help!

___ Yes, I am able to chaperone overnight if needed.
___ I am able to drive supplies to the retreat.

Please note that all overnight chaperones must have completed Protecting God's Children prior to the volunteering at the event.

NAME: _____ PHONE: _____

CHECK PAYABLE TO ST. PETER CHURCH

Total Retreat Fee: $100.00
Non-Refundable Deposit (due at registration): $30.00
Balance Due (30 days prior to retreat weekend): $70.00

Failure to pay the balance of the retreat fee within 30 days of the retreat weekend will result in a forfeiture of your student's spot on the retreat. For complete retreat registration policies, see the Confirmation Handbook.