

**Summer Kick-Off Retreat
Registration Form**

Participant's name: _____

Birth date: _____ Male/Female: _____

Parent/Guardian's name: _____

Home address: _____

Home/Cell phone: _____ T-shirt size(Adult sizes) S M L XL 2XL

My child has received the following sacraments (circle all that apply):

Baptism, 1st Communion, Confirmation

I, _____, grant permission for my child, _____,
(Parent or guardian's name)

(child's name)

to participate in this diocesan youth ministry event This activity will take place under the guidance and direction of diocesan employees and volunteers from the Diocese of Fargo. A brief description follows:

Type of event: Summer Kick-Off Retreat

Date of event: June 15th at 10am until June 16th at Noon

Ages: Open to all incoming 9th graders-graduating 12th graders

As a parent and/or legal guardian, I remain legally responsible for any personal actions taken by the above named minor ("participant").

I agree on behalf of myself, my child named herein, or our heirs, successors, and assigns, to hold harmless and defend the Diocese of Fargo, its directors and agents, chaperons, or representatives associated with the event, arising from or in connection with my child attending the event or in connection with any illness or injury or cost of medical treatment, and I agree to compensate the Diocese of Fargo, its directors and agents, chaperons or representatives associated with the event for reasonable attorney's fee and expenses arising in connection therewith.

I understand that my child will not be allowed to leave unless picked up by a parent/guardian

Signature: _____ **Date:** _____

(over)

MEDICAL MATTERS:

I hereby warrant that to the best of my knowledge, my child is in good health, and I assume all responsibility for the health of my

child. (Of the following statements pertaining to medical matters, sign only those that are applicable.)

Emergency Medical Treatment:

In the event of an emergency, I hereby give permission to transport my child to a hospital for emergency medical or surgical treatment. I wish to be advised prior to any treatment by the hospital or doctor.

In the event of an emergency, if you are unable to reach me at the above numbers, contact:

Name & Relationship: _____

Phone: _____ Family Doctor: _____ Phone: _____

Family Health Plan Carrier: _____ Policy #: _____

Signature: _____ **Date:** _____

Medications:

My child is taking medication at present. My child will bring all such medications necessary, and such medications will be well labeled. Names of medications and concise directions for seeing that the child takes such medications, including dosage and frequency of dosage, are as follows: _____

Signature: _____ **Date:** _____

No medication of any type, whether prescription or non-prescription, may be administered to my child unless the situation is life threatening and emergency treatment is required.

Signature: _____ **Date:** _____

I hereby grant permission for non-prescription medication (such as aspirin, throat lozenges, cough syrup) to be given to my child, if deemed appropriate.

Signature: _____ **Date:** _____ \

____ My child may have their picture taken. I understand that this may be used for promotional materials.

____ My child may not have their picture taken.

Special Medical Information:

The Diocese of Fargo will take reasonable care to see that the following information will be held in confidence.

Allergic reactions (medications, foods, plants, insects, etc.):

Immunizations: Date of last tetanus/diphtheria immunization: _____

Does your child have a medically prescribed diet? _____

Physical limitations? _____

Is your child subject to chronic homesickness, emotional reactions to new situations, sleepwalking, fainting?

Has your child recently been exposed to contagious disease or conditions, such as mumps, measles, chicken pox, etc.? If so, date and disease or condition: _____

You should be aware of these special medical conditions of my child: