

# "Fall Leadership Retreat"

Quad-Parishes of Green Bay - Faith Formation Center

Concent and Liability Form

~ 936 9<sup>th</sup> Street ~ Green Bay, WI ~ 54304 ~

~ 920-497-7042 ~

Participants Name: \_\_\_\_\_ Birthdate: \_\_/\_\_/\_\_ Gender: M F

Parent/Guardian Name: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

School: \_\_\_\_\_ Grade: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Type of Event: High School Fall Leadership Retreat - Minneapolis, MN

Date / Time: Friday, October 31 - Sunday, November 2

Location(s): Traveling to Minneapolis, MN

Individual In Charge: Becky VanKauwenberg 920-497-7042

Transportation: Vehicles

Cost: \$40.00 per person / plus responsible for 2 fast food meals (contact Becky for Financial Aid)

Deadline - Wednesday, Oct 22

**General Permission:** I request that my child \_\_\_\_\_, be allowed to participate in this parish activity. As a parent and/or legal guardian, I remain legally responsible for any personal actions taken by the above named minor. I agree on behalf of myself, my child named herein, or our heirs, successors, and assigns, to hold harmless and defend the Quad-Parishes of Green Bay, its officers, directors and agents, and the Catholic Diocese of Green Bay, coaches, chaperones, or representatives associated with the activity for reasonable attorney's fees and expenses arising in connection therewith.

**Videotaping and Still Photographs:** Video and still photographs may be taken during this event. This authorization form constitutes permission for my child's participation in the videotape and/or still photographs, which may only be used for future promotional efforts, including the Quad-Parish website and bulletin.

**Code of Behavior:** All event participants are representing the Quad Parishes of Green Bay during this event and we expect you will represent us well by displaying mature and responsible behavior. All participants are expected to demonstrate common courtesy and respect at all times, reflecting our Christian values.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

We are looking for adults to help chaperone our retreat. All chaperones will need to have complete a background check and Virtus training before working with minors at the Quad-Parishes. Let us know if you can help out!

Name: \_\_\_\_\_ Email or Phone: \_\_\_\_\_

Contact Becky at the Faith Formation Center With Questions 497-7042

**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 further treatment by the hospital or doctor. In the event of an emergency, if you are unable to reach me at the above numbers, contact:

Emergency Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Family Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_  
Family Health Plan Carrier: \_\_\_\_\_ Policy #: \_\_\_\_\_  
Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Other Medical Treatment:** In the event it comes to the attention of the parish, its officers, directors and agents, and the Catholic Diocese of Green Bay, coaches, chaperones, or representatives associated with the activity that my child becomes ill with symptoms such as headache, vomiting, sore throat, fever, diarrhea, I want to be called.

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 drugs (such as aspirin, throat lozenges, cough syrup) to be given to my child, if deemed appropriate.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Specific Medical Information:** The parish 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 child have a medically prescribed diet? \_\_\_\_\_

Any physical limitations? \_\_\_\_\_

Has child recently been exposed to contagious disease or condition, such as mumps, measles, chickenpox, etc? If so, date and disease or condition: \_\_\_\_\_

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