

CONFIRMATION RETREAT PERMISSION SLIP

Monday, May 27-Tuesday, May 28, 2024
Luther Crest Bible Camp, Alexandria MN

Participant's Name: _____

Gender: _____ Grade: _____

Parent/Guardian's Name: _____

Cell Phone: _____ Other Emergency Phone: _____

I, _____ (Parent or guardian's name) grant permission for my youth, _____ (Youth's name) to participate in this parish event that requires transportation to a location away from the parish site. This activity will take place under the guidance and direction of parish employees and/or volunteers from our ACC (all six parishes).

RULES:

- * No drugs or alcohol.
- * No going into the opposite gender dorms.
- * No Electronics: Phones and all electronics are to be left at home. During the retreat we want teens to be present and focused on their peers and keep a safe environment for all attending. Electronics will be collected from anyone who brings them when we load the bus and returned when we get back.
- * Be present for all scheduled activities during the retreat.
- * Be respectful of all people and property.

As 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 six parishes in our ACC, its officers, directors, employees and agents, chaperones and the Diocese of St. Cloud, its employees, agents or representatives associated with the event, from any claim arising from or in connection with my youth attending the event or in connection with any illness or injury (including death) or cost of medical treatment in connection therewith, and I agree to compensate the parish, its officers, directors and agents, the St. Cloud Diocese or representative associated with the event for reasonable attorney's fees and expenses which may incur in any action brought against them as a result of such injury or damage, unless such claim arises from the negligence of the parish.

Parent Signature: _____

Print Name: _____ Date _____

Youth Signature: _____

Please return these permission slips by Wed., April 24, 2024, or by mailing or dropping off at Centre For Christ, 235 Main St. S., Sauk Centre, MN 56378

Please fill out the back ->

MEDICAL MATTERS: I hereby warrant that to the best of my knowledge, my youth is in good health, and I assume all responsibility for the health of my youth.

(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 youth 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:

Name & relationship: _____ 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, or representatives associated with the activity that my youth becomes ill with symptoms such as headache, vomiting, sore throat, fever, diarrhea, I want to be called at: _____

Signature _____ Date: _____

Medications: My youth is taking medication at present. My youth will bring all such medications necessary, and such medications will be well labeled. Names of medications and concise directions for seeing that the youth 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 youth unless the situation is life threatening and emergency treatment is required.

Signature: _____ Date: _____

OR (only sign one option in the box)

I hereby grant permission for **non-prescription medication** (such as non-aspirin products, i.e. acetaminophen or ibuprofen, throat lozenges, cough syrup) to be given to my youth, if deemed appropriate.

Signature: _____ Date: _____

Specific Medical Information: The parish will take care to see that this information will be held in confidence.

Please list any allergic reactions or medical conditions we should be aware of (medications, foods, plants, insects, etc.):

Is your child currently following any specific diet that we need to accommodate?

Does your child have any physical limitations?