

# “To the Heart” – Confirmation Retreat

## REGISTRATION FORM March 15 - 17 Fee \$150

### PARENTAL/GUARDIAN CONSENT FORM & LIABILITY WAIVER

Participant's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Participant's Email Address: \_\_\_\_\_ Participant's Phone: \_\_\_\_\_

T-Shirt Size (Adult Sizes):    Small    Medium    Large    XL    XXL    XXXL

Home Address \_\_\_\_\_ City/Zip Code \_\_\_\_\_

Mother's Name \_\_\_\_\_ Mom's Phone \_\_\_\_\_

Mom's E-mail: \_\_\_\_\_

Father's Name \_\_\_\_\_ Dad's Phone \_\_\_\_\_

Father's E-mail: \_\_\_\_\_

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

Emergency Contact Relationship: \_\_\_\_\_

Grade (On Date of Event): \_\_\_\_\_ Age (On Date Of Event): \_\_\_\_\_ Sex M / F

#### CONSENT & LIABILITY WAIVER

Important! To be filled out by the Parent/Guardian for youth under 18 years of age.  
(If participant is 18 years of age or older, consent must be signed by the individual)

I (name of parent/guardian) \_\_\_\_\_, grant permission for my child,  
(participant's name), \_\_\_\_\_ to participate in **This is your Faith – Confirmation Retreat**  
**March 15 – 17 at the Cristian Renewal Center in Dickinson, TX**

I agree on behalf of myself, my child's other parent if known or living (name of other parent), \_\_\_\_\_, my child name herein, or our heirs, successors, and assigns and defend the Archdiocese of Galveston-Houston, the sponsoring parish (its pastor, youth ministry leader, principal, other agents, etc.) or any representatives associated with the scheduled activity unless the parties involved were careless and negligent.

*In signing this form I certify that all information contained herein is true and accurate to the best of my knowledge.*

\_\_\_\_\_  
Signature (Parent/Guardian) Date

**YOUTH PARTICIPANT:** In signing the line below I agree to abide by any/all policies and rules established for this event. Should I not be able to maintain the guidelines and expectations of the adults and my peers, I understand that there will be consequences for my actions, including being removed from the activity and being sent home at my parent's expense.

\_\_\_\_\_  
Signature (Youth Participant) Date

As parent/guardian, I understand that promotional pictures and videos (individual and group) will be taken during this event. I give permission for my son's/daughter's picture to be used for promotional materials (newsletter, web page, calendars, power point, video, etc.) in highlighting the event.

\_\_\_\_\_  
Signature (Parent/Guardian) Date

*If an item is not applicable, write "N/A"*

**MEDICAL CONSENT FORM****Participant Name:** \_\_\_\_\_**Medical Matters**

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

**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 and you are unable to reach me, contact:

Name &amp; Relationship: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Family Doctor: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

**Medications**

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

My child is taking the following medication at the present time:

Medication(s): \_\_\_\_\_ Dosage: \_\_\_\_\_

Administer: \_\_\_\_\_

Initial next to **ONE** of the following:\_\_\_\_\_  
(Initial) I hereby **Grant Permission** for nonprescription medication (such as Tylenol, Benadryl, throat lozenges, cough syrup, etc.)  
to be administered to my child if deemed advisable. I understand that Aspirin will not be given to my son/daughter.\_\_\_\_\_  
(Initial) I hereby **Do Not Grant Permission** for medication of any type (prescription or nonprescription) to be administered to  
my child unless the situation is life-threatening and emergency treatment is required.**Medical Conditions Information:** (Personnel will take reasonable care to see that the following information will be held in confidence.)

My son/daughter has:

- Had an episode of the following or has been diagnosed:  Seizures  Asthma  Diabetic
- Allergic reactions to the following (foods, dyes, medications, latex, etc.) \_\_\_\_\_
- Has had a medical surgery within the last six months?  Yes  No Still under doctor's care  Yes  No
- Has a medically prescribed diet? \_\_\_\_\_
- The following physical limitations: \_\_\_\_\_
- Immunizations current and up to date:  Yes  No Date of last tetanus/diphtheria immunization \_\_\_\_\_
- You should also be aware of these special medical and/or psychological conditions of my child (e.g. depression, A.D.D., etc):  
\_\_\_\_\_

**Insurance Information:**  **No, my child does not have medical insurance at this time.**

Insurance Carrier: \_\_\_\_\_ Name of Insured: \_\_\_\_\_

Insurance Policy Number: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

In the event it comes to the attention of the chaperones associated with the activity that my child becomes ill with repeated symptoms such as headache, vomiting, sore throat, fever, diarrhea, I want to be called immediately. If this will be a long distance call, I want to be called collect (with phone charges reversed to myself). I fully understand the foregoing statements and sign this Parental/Guardian Medical Consent Waiver knowingly, freely, and willingly.

\_\_\_\_\_  
Signature (Parent/Guardian must sign for anyone under 18 years of age)\_\_\_\_\_  
Date