AWAKEN SPRING 2018 RETREAT PERMISSION SLIP

1. Consent: I grant my permission for my child _____ to attend and participate in the **AWAKEN SPRING 2018 HIGH SCHOOL RETREAT on FRIDAY, MARCH 23rd at 6pm to SUNDAY, MARCH 25th at 12pm at LASALLE MANOR RETREAT CENTER IN PLANO, ILLINOIS.**

2. Student Cooperation: My child agrees to abide by all the rules of aforementioned and to obey the staff in charge of this retreat. The Parish, School, and Diocese will not be liable for my child's failure to cooperate and/or to abide by the rules. Any infraction of the rules may result in the immediate dismissal of my child from the retreat at my expense and without refend to me of the costs paid for the retreat.

3. First Aid/Emergency Treatment: I authorize the School, Parish, and Diocese and its employees and volunteers to administer first-aid to my child if deemed necessary and appropriate to preserve the life, limb or well-being of my child. I authorize the Parish, School, and Diocese to contact and engage medical personnel and arrange for emergency treatment of my child, including transportation for medical, dental, surgical or hospital care or diagnosis, and I consent to that treatment for my child. I agree that I am financially responsible for such medical treatment.

4. **Administration of Medication provided by parent/guardian of child: If my child needs to take prescription or non-prescription medication during this retreat, I have provided the medication in its original container. I give permission to an adult employee or adult volunteer to administer the medication or assist in the administration to my child in the dosage prescribed by the presciption or, for the non-prescription medication, the dosage recommended on the container by the manufacturer. ****If there are explicit instructions for this medication, I state them here:**

_____

_____.

5. Release: I hearby release and discharge the Diocese of Rockford and its Bishop, and the Parish and School, and the officers, directors, employees, and volunteers of same, from all claims for personal injuries or property damage that I or my child may suffer while my child is attending and/or partcipating in the retreat, unless the injuries or

damage resulted from willful misconduct of the Diocese, the Parish, the School or its employees. If I have provided medication for my child to take during this retreat, I hereby release and discharge the Diocese of Rockford and its Bishop, and the Parish and School, and the officers, directors, and employees and volunteers of same, from all claims for personal injuries or property damage that I or my child may suffer as a result of the administration of said medication to my child, whether by my child and/or an adult employee and/or an adult volunteer; unless the injuries or damage resulted from willfull misconduct of the Diocese, the Parish, the School or its employees.

DATE: _____

PARENT GUARDIAN/SIGNATURE: _____

NAME: _____
[PLEASE PRINT]

TRANSPORTATION: With your registration, you are guaranteed transportation to/from Holy Cross Catholic Church to/from LaSalle Manor via bus. Please mark whether or not you will be taking advantage of this transportation.

_____YES _____NO

FEE: $50.00

AMOUNT ENCLOSED: $_____

CHECK _____ CASH _____

E-MAIL FOR REGISTRATION CONFIRMATION:

_____

T-SHIRT SIZE: S M L XL

STUDENT REGISTRATION EMERGENCY FORM

PARISH/SCHOOL/DIOCESE ENTITY: HOLY CROSS CATHOLIC CHURCH, BATAVIA

FULL NAME OF CHILD: _____

SEX: M F DATE OF BIRTH: _____

SPECIAL HEALTH CONDITION (DESCRIBE)/MEDICATION/DIETARY NEEDS, ETC.:

_____

HOME ADDRESS: _____
NAME OF MOTHER & PHONE: _____
NAME OF FATHER & PHONE:
_____

ALTERNATE ADULT & PHONE (IN CASE PARENT CANNOT BE REACHED):
_____

PHYSICIAN OF CHOICE: _____
ADDRESS: _____
PHONE: _____

HOSPITAL OF CHOICE: _____
ADDRESS: _____
PHONE: _____

IF I, OR RESPONSIBLE ADULT, AND PHYSICIAN OF CHOICE AS INDICATED ABOVE CANNOT BE REACHED IN AN EMERGENCY AND IMMEDIATE MEDICAL AND/OR HOSPITAL ATTENTION IS INDICATED, I HEREBY AUTHORIZE THE TRANSPORTING OF MY CHILD TO A HOSPITAL OR PHYSICIAN FOR TREATMENT.

DATE: _____

SIGNATURE: _____

PRINTED NAME: _____