Logos Retreat Registration

October 19th-21st, 2018 @ Camp Kappe, Plantersville

Forms and $140 Fee DUE October 4rd

Participant's Name_____ **Date of Birth**_____

Home Address_____ **City/Zip Code**_____

Parent(s)/Guardian(s)_____ **Home Phone (___)**_____

Alternate Phone Number: (___)_____ ☐ **Cell Phone or** ☐ **Work**

Parish: St. Helen Catholic Church **School:** _____

Grade (On Date Of Event): 9th or 10th **Age (On Date Of Event):** _____ **Sex M / F**

Parent's Email Address: _____

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

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 **St. Helen Shocking Truth Retreat to be held at Camp Kappe in Plantersville, TX from January 5th-7th, 2018**.

I agree on behalf of myself, my child's other parent if known or living (name of other parent), _____, my child named 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**

VIDEO/PHOTOGRAPHY CONSENT - REQUIRED

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**

PLEASE COMPLETE BOTH PAGES OF THIS FORM AND LEAVE NO BLANKS!!!
If an item is not applicable, write "N/A"

Archdiocese of Galveston-Houston **Office of Youth Ministry**

MEDICAL CONSENT FORM

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 & 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:

_____ I hereby **Grant Permission** for nonprescription medication (such as Tylenol, Benadryl, throat lozenges, cough syrup, etc.)
(Initial) to be administered to my child if deemed advisable. I understand that Aspirin will not be given to my son/daughter.

_____ I hereby **Do Not Grant Permission** for medication of any type (prescription or nonprescription) to be administered to
(Initial) 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

PLEASE COMPLETE BOTH PAGES OF THIS FORM AND LEAVE NO BLANKS!!!
If an item is not applicable, write "N/A"