

# Shocking Truth Retreat Registration

January 5<sup>th</sup>-7<sup>th</sup>, 2018 @ Camp Kappe, Plantersville

**Forms and \$135 Fee DUE December 3<sup>rd</sup>**

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): 9<sup>th</sup> or 10<sup>th</sup> 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 5<sup>th</sup>-7<sup>th</sup>, 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"**

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 \_\_\_\_\_