

# 2 1st Annual "GETAWAY" RETREAT

## March 2-4, 2012

### 9<sup>th</sup>~12<sup>th</sup> Graders @ Sky Ranch, near Van Texas

### Cost: \$150 - Deadline January 30, 2012

Please return form & payment to Seton Youth Ministry Office—972-596-5505  
(make checks payable to St. Elizabeth Seton...sorry, no credit cards)

Packets with info. ie. check-in, what to bring, etc....will be mailed approximately one week prior to the retreat



**PLEASE PRINT—YOUTH INFO:**

(CIRCLE) T-Shirt Size (Adult sizes) S M L XL 2XL 3XL 4XL

YOUTH—Last name \_\_\_\_\_ First name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Gender: M or F

Hm. Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Youth E-Mail \_\_\_\_\_ Youth Mobile Ph \_\_\_\_\_

Church \_\_\_\_\_ School \_\_\_\_\_ Grade \_\_\_\_\_

Roommate Request: 1st Choice - \_\_\_\_\_, 2nd Choice - \_\_\_\_\_

**PARENT, GUARDIAN or CONSERVATOR—INITIAL** any that apply **\*\*[DO NOT INITIAL ALL AREAS AS ONE MAY CANCEL OUT ANOTHER]\*\***

\_\_\_\_\_ This child takes no medication and will bring no medication with him/her.

\_\_\_\_\_ This child takes medication/s and will self-medicate. The child will bring all such medications necessary, and such medications will be clearly labeled. I understand that the child will be required to turn all medication(s) over to a supervising adult designated to keep medication(s). I further understand that it will be this child's responsibility to present himself/herself at a location designated for returning medication(s) to this child at the frequencies/times listed below. I understand that the adult to whom this child surrenders the medication has no medical training and this adult will not measure dosages. This child will return the medication(s) to the adult after he/she self-medicates. At the conclusion of the event it will be this child's responsibility to pick up remaining medication(s), if any, at the self-medication designated location. Names of medications and exact dosage and frequencies/times are as listed below:

**NOTE:** Should your child have an Emergency Injection Device (Epi-Pen), Diabetic Condition, Asthmatics with a rescue inhaler, or other special medical condition, it is important to provide a clear description as to the nature of the medical condition and any medication. This is important for situations where the youth becomes unable to self-administer these treatments and to communicate with Emergency Response Personnel. If a child, who is normally able to self-administer these medications becomes unable to self-administer or is in distress, youth ministers, volunteers, or other parish personnel will immediately call 911 to summon Emergency Medical Personnel to respond to the medical emergency. **Youth ministers, volunteers, and other parish personnel are NOT trained to administer these types of emergency medications.**

\_\_\_\_\_ This child takes medication but is **unable to self-medicate**. Child's parent/guardian/conservator will provide all medications, for an adult to dispense.

\_\_\_\_\_ **I grant permission** for the following nonprescription medication to be given to this child:

Non-aspirin/pain reliever Yes \_\_\_\_\_ No \_\_\_\_\_ # of tablets per dosage \_\_\_\_\_  
Throat Lozenge Yes \_\_\_\_\_ No \_\_\_\_\_  
Decongestant Yes \_\_\_\_\_ No \_\_\_\_\_ # of tablets per dosage \_\_\_\_\_  
Antacid Yes \_\_\_\_\_ No \_\_\_\_\_  
Antihistamine Yes \_\_\_\_\_ No \_\_\_\_\_ # of tablets per dosage \_\_\_\_\_  
Other \_\_\_\_\_ Dosage \_\_\_\_\_

**Specific Medical Information:**

Allergic reactions (medications, foods, plants, insects, etc.) \_\_\_\_\_

Immunizations: (date of last tetanus/diphtheria immunization) \_\_\_\_\_

Other Medications child currently takes: \_\_\_\_\_

Any physical limitations: \_\_\_\_\_

Has child recently been exposed to contagious disease or condition such as mumps, measles, chicken pox, etc.? Y N

If so, date and disease or condition. \_\_\_\_\_

Any other special medical conditions of this youth that we should be aware of?

\_\_\_\_\_ **No medication of any type**, prescription or nonprescription, may be given to this child, unless emergency treatment is required in life-threatening case.

**PLEASE COMPLETE BOTH SIDES OF FORM**

**PLEASE PRINT**

YOUTH participant Last Name \_\_\_\_\_, First Name \_\_\_\_\_

**TO BE FILLED OUT BY PARENT, GUARDIAN, CONSERVATOR**

**CONSENT TO PARTICIPATE AND LIABILITY RELEASE**

I, \_\_\_\_\_ the parent/guardian/conservator of \_\_\_\_\_ (child name) grant permission for my son/daughter to participate in all youth activities and functions.

I understand that as parent/guardian/conservator, I remain legally responsible for any personal actions taken by my son/daughter. I recognize the inherent risk associated with the various youth activities that my son/daughter will be participating in. I agree on behalf of myself, my son/daughter named herein, my heirs, successors, and assigns to indemnify, defend, and hold harmless **St. Elizabeth Ann Seton Parish** and the Roman Catholic Diocese of Dallas, their employees and/or volunteers from any and all claims (unless due to the Sole or Gross NEGLIGENCE of the Parish) for illness, injury, death, and the cost of medical treatment therewith, arising from or in any way connected with my son/daughter participating and/or attending the various youth programs and activities during this formation year noted above.

In the event any legal action is taken by either party against the other party to enforce any of the terms and conditions of this release, it is agreed that the unsuccessful party to such action shall pay to the prevailing party therein all reasonable court costs, reasonable attorneys' fees and expenses incurred by the prevailing party.

**AUTHORIZATION OF CONSENT TO TREAT MINOR**

I, \_\_\_\_\_ am the (initial one) \_\_\_ parent \_\_\_ guardian or \_\_\_ conservator of \_\_\_\_\_ (child name), a minor, and as such do hereby authorize **St. Elizabeth Ann Seton Parish**, its youth ministry leaders, employees, contractors and volunteers as agent(s) for the undersigned to consent to any x-ray examination, anesthetic, medical, dental, or surgical diagnosis or treatment, and hospital care which is deemed advisable by, and is to be rendered under the general or specific supervision of any physician or surgeon licensed under the laws of the jurisdiction where such diagnosis or treatment may be given, whether such diagnosis or treatment is rendered at the office of said physician, at a hospital, or at any other location. It is understood that this authorization is given in advance of any specific treatment or diagnosis, but is given to provide authority and power of treatment, or hospital care which the aforementioned physician in the exercise of best judgment may deem advisable. This authorization is given pursuant to the provisions of Chapter 32 of the Texas Family Code. This authorization shall remain effective throughout the specific event dates listed above. In consideration of acceptance of this authorization, but without any time limitation and without any future right of revocation, I hereby release, defend and hold harmless the Parish and Roman Catholic Diocese of Dallas (Diocese), their officers, directors, agents, employees, volunteers, youth ministry leaders, and contractors from all claims, liabilities and loss in any way arising out of or in connection with or relating to such treatment and treatment decisions.

Insurance Carrier: \_\_\_\_\_

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

Social Security # (optional): \_\_\_\_\_

**\*\*PLEASE ATTACH A PHOTOCOPY, front and back, OF Child's HEALTH INSURANCE CARD\*\***

**AUDIO/VISUAL RECORDING AND PHOTOGRAPHY CONSENT**

On occasion, video recordings, audio recordings, photographic slides, and photographs are taken of children and youth during church and diocesan sponsored activities. These are utilized in newsletters, websites, event promotion, advertisements and other printed media. As the State of Texas does not prevent audio or video recording or the photographing of children/youth (*with the exception of Senate Bill 1, Section 26.009, which deals specifically with school districts*), it does encourage parental consent. *Additionally, current video recordings and photographs assist law enforcement agencies dealing with the Missing Children's Program.*

I consent to the use of such materials in which my child may appear. I release the staff and volunteers of **St. Elizabeth Ann Seton Parish** and the Roman Catholic Diocese of Dallas from any liability connected with the use of my child's picture or audio/video recording as part of any of the above or similar activities.

Name of—Parent, Guardian, Conservator \_\_\_\_\_

Signature of Parent/Guardian/Conservator \_\_\_\_\_

Date Signed \_\_\_\_\_

Home Phone Number \_\_\_\_\_ Mobile Phone Number \_\_\_\_\_

Address (if different than the child's) \_\_\_\_\_

Parent E-Mail \_\_\_\_\_

PRINT—Name of Secondary Emergency Contact \_\_\_\_\_

Mobile Phone Number \_\_\_\_\_

**PLEASE COMPLETE BOTH SIDES OF FORM**