

**THE FALL RETREAT PERMISSION & REGISTRATION FORM**

November 16-18, 2018

Name \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_ T-Shirt Size \_\_\_\_\_  
( )  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone \_\_\_\_\_  
School \_\_\_\_\_ Grade \_\_\_\_\_ Birthdate \_\_\_\_\_ Parish \_\_\_\_\_  
Student Cell Phone \_\_\_\_\_ Student E-Mail \_\_\_\_\_ Parent Email \_\_\_\_\_

**Permission for Child to Participate**

I, the parent or guardian of above mentioned child, give permission for my child to participate in the above mentioned event/trip on November 16-18, 2018.

**Medical Authorization**

In the event of any injury or illness to my/our child during his/her participation in this program, I hereby give my permission for the necessary medical treatment to be given to my child. I agree that in case of injury to my child, we will apply my hospitalization and/or or accident insurance toward payment of the expenses incurred and will not look to The Fall Retreat, parish staff or any other program sponsor or volunteer for the payment of any medical costs or injury related costs.

Parent/Guardian Signature \_\_\_\_\_ Name (Please Print) \_\_\_\_\_ Date \_\_\_\_\_

Parent/Guardian Phone Number(s) \_\_\_\_\_ Parent Email \_\_\_\_\_

Insurance Company \_\_\_\_\_ Policy and/or ID Number \_\_\_\_\_

Emergency Contact Name \_\_\_\_\_ Emergency Contact Phone Number \_\_\_\_\_

**Consent to Treat**

I, the undersigned parent/guardian of \_\_\_\_\_ (child's name), a minor, do hereby authorize treatment of my child by a licensed medical physician in case of any accident or illness that may so arise, or any hospitalization necessary. This medical consent will remain effective until **Sunday, November 19<sup>th</sup>**.

Parent/Guardian Signature \_\_\_\_\_ Name (Please Print) \_\_\_\_\_ Date \_\_\_\_\_

**MEDICAL MATTERS:**

I hereby warrant that to the best of my knowledge, my child is in good health, and I assume all responsibility for the health of my child.  
(Of the following statements pertaining to medical matters, **sign only those in accordance with your wishes.**)

1) Medications: My child is **TAKING MEDICATION AT PRESENT**. My child will bring all such medications necessary, and such medications will be well labeled. My child will be responsible to administer his/her own medication.

Name of medication, time(s) to be administered, and dosage: \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

2) I **grant PERMISSION FOR NON-PRESCRIPTION MEDICATION** (Tylenol, throat lozenges, cough syrup) to be given to my child if deemed advisable.

Signature \_\_\_\_\_ Date \_\_\_\_\_

3) **NO MEDICATING of any type**, whether prescription or non-prescription may be administered to my child unless the situation is life-threatening and emergency treatment is required.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Known allergies: \_\_\_\_\_

Special dietary needs: \_\_\_\_\_

Is child subject to chronic homesickness, emotional reactions to new situations, sleepwalking, fainting?  No  Yes

Does child have any other special needs?  No  Yes – Please briefly describe \_\_\_\_\_