PART "A"

TEEN ACTS RETREAT

Adoration, Community, Theology, Service

Retreat Registration/Consent and Liability Waiver Form

Please Print

Participant's Name: _____Date of Birth_____
Home address: _____City/State/Zip: _____
Home Phone: _____ E-mail Address: _____
Sex: _____ Grade: _____ Graduation Year: _____School: _____
Practicing Catholic: [ ]Yes [ ]No; Parish/Church:_____ City:_____
T Shirt Size (Adult Sizes) _____

Parent or Guardian's Name: _____Home phone: _____
Business Phone:_____ Cell Phone:_____

I, _____grant permission for my teen, _____ to participate in this youth ministry event including transportation as required. This activity will take place under the guidance and direction of adult and youth volunteers of the ACTS Community.

The Teen ACTS retreats' goals are to deepen one's relationship with Jesus Christ through interaction of youth and adults including religious, spiritual, moral, and social issues, through prayer and scripture sharing, and through physical games and exercises.

The Teen retreat begins at the Bishop DeFalco Retreat Center 2100 N. Spring in Amarillo on Thursday evening and ends on Sunday following the closing Mass and reception. The cost of the retreat is **$175.00**. Teen ACTS Retreat is open to teens that are 15 years of age or older and have completed at least one semester of high school.

As the parent and/or legal guardian, I remain legally responsible for any personal actions taken by the above named minor "participant".

I agree on behalf of myself, my teen named herein, our heirs, successors and assigns to hold harmless and to defend the Bishop DeFalco Retreat Center, its officers, directors and agents, the Diocese of Amarillo, and ACTS volunteers from any and all liability for illness, injury or death arising from or in connection with my teen attending the above named event and I agree to compensate the retreat center, its officers, directors and agents and the Diocese of Amarillo or representative associated with the event for reasonable attorney's fees and expenses in connection therewith.

Parent or Guardian Signature: _____

A prompt response is recommended because registrations are made on a first received, first served basis regardless of when your name was submitted or if you are prepaid. You will receive a letter two weeks before the retreat describing what you will need to bring for the retreat. For further retreat or registration information, contact Cindy Cross at 806-655-3583.

Please make checks payable and mail your registration form **(PARTS A AND B)** to:
ACTS Retreat-Teen
P.O. Box 30701 Amarillo, TX 79120

PLEASE INCLUDE THE FEE OF $175.00
(A minimum deposit of $100.00 is required to be put on the list; the entire $175.00 is due before the retreat.)
Cancellations made seven or more days prior to the start of the retreat will receive a full refund. The deposit of $100 will be retained for cancellations made **less than seven days prior to the start of the retreat.**

TEEN ACTS RETREAT

MEDICAL CONSENT AND PERMISSION TO TREAT

To the best of my knowledge, my teen, _____, is in good health, and I assume all responsibility for the health of my teen. **Emergency Medical Treatment:** In the event of an emergency, I hereby grant permission to transport my teen to a hospital for emergency medical treatment. **_____Yes _____No** (Preferred Hospital _____)
I wish to be advised prior to any further treatment by the hospital or doctor. **_____Yes _____No**

Parent/Guardian's Name: _____
Home Address: _____
Home Phone: (_____)_____Business Phone: (_____)_____
Cell Phone: (_____)_____ Pager:(_____)_____
If you are unable to reach me, please contact:
Name: _____
Relationship to me or my teen: _____
Home Phone: (_____)_____Business Phone: (_____)_____

Family Doctor:_____ Phone number: _____
Please include a photocopy of your Insurance Card (front and back).

- Insurance Carrier: _____Policy Number_____
- My teen is taking medication and will bring all of the medicines in their original containers.
- I hereby grant permission for non-prescription medication (such as cough drops, cough syrup, Tylenol, etc.) to be given to my teen if necessary: **_____Yes _____No**
- I understand that aspirin will not be given to my teen without express permission. I hereby grant such permission: **_____Yes _____No** My teen is allergic to the following (medications, foods, plants, insects, etc.)_____
- My teen's immunizations are current and up to date: **_____Yes _____No**
- My teen's last tetanus/diphtheria immunization: _____
- My teen has the following physical limitations: _____
- My teen has the following food allergies: _____
  fainting, bed wetting, etc. **_____Yes _____No** If Yes, please explain:
  _____.
- My teen has recently been exposed to a contagious disease or condition such as mumps, measles, chickenpox, etc. **_____Yes _____No** If yes, please state the date and disease or condition: _____.
- My teen is suffering from a psychological condition which may affect or limit his or her ability to participate in this activity. **_____Yes _____No** If yes, please explain.
  _____.

_____ _____
Signature of Parent or Guardian Date