



# HOLY ROSARY TEEN ACTS RETREAT APPLICATION June 29 - July 2, 2023

Participant Name: \_\_\_\_\_ Age: \_\_\_\_\_ (on 6.29.23) Birth Date: \_\_\_\_\_  
Gender: \_\_\_\_\_ Cell #: \_\_\_\_\_ School: \_\_\_\_\_ Graduation year: \_\_\_\_\_  
Participant Email: \_\_\_\_\_ Parish: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ St/Zip: \_\_\_\_\_ Tshirt size: \_\_\_\_\_  
Parent/Guardian Name: \_\_\_\_\_ Parent email: \_\_\_\_\_  
Cell phone: \_\_\_\_\_ Home: \_\_\_\_\_ Work: \_\_\_\_\_  
Address (if different from participant): \_\_\_\_\_ City: \_\_\_\_\_ St/Zip: \_\_\_\_\_

**PLEASE MAIL APPLICATION, COMPLETED PARENT/GUARDIAN CONSENT FORM  
AND MEDICAL CONSENT FORM ALONG WITH A \$25.00 DEPOSIT TO: (make checks payable to Holy Rosary ACTS)**

**Eric Oeding -- 1035 Eilers St. Schulenburg, Texas 78956**

DEPARTURE LOCATION/TIME: St. Rose of Lima Family Life Center 405 Black St.  
Schulenburg, Tx 78956 / Thursday, June 29<sup>th</sup> 6:30pm RETREAT  
LOCATION: Cathedral Oaks Retreat Center, Weimar, Tx  
RETURN MASS & MEAL LOCATION: St. Rose of Lima Catholic Church, Schulenburg, Tx, 10 A.M.  
Schulenburg Hall, 405 South St. Schulenburg, TX

***YOUTH PARTICIPANTS MUST BE BETWEEN THE AGE OF 14 & 18  
(OUTGOING FRESHMEN THROUGH JUST GRADUATED SENIORS).***

*The \$25.00 Fee Is A Deposit Credited Toward The Total Retreat Cost Of \$100.00\*.  
The Remainder Is Due On Or Before Thursday, June 29<sup>th</sup>. The Balance Can Be Paid During Check In.  
If You Are Not Accepted Or Have To Cancel, The Initial Deposit Fee Will Be Returned To You.  
\* If you want to attend and are not able to pay the fee, scholarships are available.*

***ALL PARTICIPANTS MUST ADHERE TO THE CODE OF CONDUCT:***

*-Dress shall be modest. No short-shorts or open/loose tops are allowed. Remember that you will be going to Mass each day and your attire should be appropriate. Shorts are acceptable.*

*-Items needed for retreat: Pillow, Blanket & sheets or sleeping bag (single size mattress), Couple pair of shoes (at least one w/ closed toes), Personal toiletry items, Bath towel, Flashlight, Bug spray*

*-All rules outlined by the directors and co-directors must be followed. Failure to obey rules will result in removal from the retreat.*



# The Catholic Diocese of Victoria in Texas

## YOUTH PERMISSION FORM/MEDICAL RELEASE

NAME \_\_\_\_\_ Gender \_\_\_\_\_ Grade \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_  
St/Zip \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_  
Age \_\_\_\_\_ Birth date \_\_\_\_\_ Parish \_\_\_\_\_

PARENT/LEGAL GUARDIAN'S NAME \_\_\_\_\_

Address (if different than above) \_\_\_\_\_

Phone (\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_ Wk (\_\_\_\_) \_\_\_\_\_

I request and give my consent for my son/daughter, \_\_\_\_\_ to participate in all church/school sponsored activities from Thursday, June 29 through Sunday, July 2, sponsored by Holy Rosary Acts Core and/or by the Diocese of Victoria. I understand that my son/daughter will be under the supervision of diocesan and/or parish/school personnel. I give my permission to the personnel in charge of the activity to search my child's belongings, bag, backpack, or other container if it is deemed necessary to do so. As parent or legal guardian I agree to defend, indemnify and hold harmless the Diocese of Victoria and Holy Rosary Acts Core, its clergy, officers, agents, employees and volunteers from any claims, costs or expenses for property damages, personal injuries or other damages arising out of my son/daughter's participation in the above mentioned activity or during the transportation to and from the event. I grant permission for non-prescriptive medication (e.g. tylenol, throat lozenges, cough syrup, pepto-bismol, etc.) and routine nonsurgical medical care to be given to my son/daughter if deemed advisable by the supervising diocesan and/or parish personnel. In case of an emergency, I also grant permission to transport my child to the nearest hospital for emergency medical or surgical treatment and for an authorized adult sponsor to sign for treatment if I cannot be located.

\_\_\_\_\_ Date

\_\_\_\_\_ Parent's Signature

My son/daughter is allergic to: \_\_\_\_\_

My son/daughter takes the following medication (name, dosage): \_\_\_\_\_

This medication is for: \_\_\_\_\_

Medication that my son/daughter is allergic to: \_\_\_\_\_

Last immunization/booster for Diphtheria/Tetanus: \_\_\_\_\_

Any specific medical problems: \_\_\_\_\_ Any physical limitations: \_\_\_\_\_

Family Physician \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Name of Insurance Company \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_

City/St/Zip \_\_\_\_\_

Name of Insured \_\_\_\_\_ Policy # \_\_\_\_\_

Group or Plan # \_\_\_\_\_ ☐ I do not have insurance at this time.

### Contacts in case of emergency and parent cannot be reached:

Name \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_ Other Phone (\_\_\_\_) \_\_\_\_\_

Name \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_ Other Phone (\_\_\_\_) \_\_\_\_\_

\_\_\_\_\_ My child may also be released to the emergency contact adults listed above after an event. (Please initial line)

\_\_\_\_\_ My child has a valid driver's license and may drive to and from events. (Please initial line)



# The Catholic Diocese of Victoria in Texas

## POLICY FOR ADMINISTRATION OF MEDICATIONS BY DIOCESE OF VICTORIA DESIGNEES

**This form specifically pertains to “over the counter” medications and prescription medications provided by the legal guardian for participants in parish/diocesan sponsored activities.**

- A. Medications prescribed by a licensed healthcare provider and dispensed by a registered pharmacist may be administered for the duration of the parish/diocesan activity by authorized diocesan designee and only with this signed Medication Request Form.
- B. “Over the Counter” medication provided by the parent may be administered for the duration of the parish/diocesan activity by authorized parish/diocesan designee only with this signed, complete Medication Request Form.
- C. A prescribed medication may be administered for as long as the licensed healthcare provider requests based on the directions provided on the prescription. No medication shall be administered after its expiration date has passed.
- D. All prescribed and “over the counter” medication **must be in the original container and properly labeled.**
- E. Medication Request Form must be signed by the parent or legal guardian.

**Please complete this form only if your child will need medication administered during the event. Children MAY NOT keep their own medication with them, except for an epinephrine (epi-) pen, insulin, and/or an inhaler.**

### MEDICATION REQUEST FORM

Event: \_\_\_\_\_ Date range of event: \_\_\_\_\_  
Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Name of Medication:	Dosage:	Route: (oral, inhaled, etc.)	Time/Frequency Taken:

Will there be any restriction for activities while on any above listed medication? If “yes” please list any restrictions or special instructions:

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I consent for this medication to be administered by a parish/diocesan/school employee or volunteer of the Diocese of Victoria. I further release the Diocese of Victoria and its personnel from any liability resulting from any adverse effect that this medication may cause when dispensed at parish/diocesan activities. I understand that if I do not agree to this policy, “over the counter” medications and prescription medications provided by the legal guardian for participants will not be administered at the above mentioned event.

Date: \_\_\_\_\_ Parent or Legal Guardian Signature: \_\_\_\_\_