ARCHDIOCESE OF BALTIMORE
DIVISION OF YOUTH & YOUNG ADULT MINISTRY

PERMISSION FORM AND RELEASE for Confirmation Overnight Retreat September 15-17, 2017

Youth Name: _____Home Phone: _____

Parent Name: _____Work Phone: _____

Other number where Parent can be reached: _____

Address _____

City/State/Zip _____

Date of Birth:_____ Male Female (please circle)

In consideration of the wholesome recreational and learning experience in which my son/daughter will participate, I as parent or guardian of my son/daughter, do hereby agree to allow my son/daughter to accompany the Confirmation Class of St. Augustine/St. James/St. Joseph Church to: Overnight Confirmation Retreat at Skycroft Conference Center, Middletown.

I/we acknowledge receipt of the attached information sheet describing the planned activities.

In consideration of the opportunity for my son/daughter to participate in the Program, I agree to RELEASE AND HOLD HARMLESS AND INDEMNIFY St. Augustine/St. James/St Joseph Catholic Church, the Division of Youth & Young Adult Ministry, the Roman Catholic Bishop of Baltimore and his successors, a Corporate Sole, and all their agents, servants and employees from any liability, claims, demands and causes of action arising out of or relating to any loss, damage or injury sustained in connection with or arising out of my son/daughter's participation in the Program.

I hereby grant permission to any staff person to obtain medical care from a licensed physician, hospital, or medical clinic for my son/daughter in the event that I cannot be reached. (Check one of the following:)

I am covered by hospitalization and medical insurance under policy #_____issued by . _____.

I do not have medical coverage and assume responsibility for the cost of hospitalization and medical care for my son/daughter.

I hereby grant permission to any staff person to provide the following over-the-counter drugs to my son/daughter if requested by my son/daughter (Circle all that apply:)

Tylenol Benadryl Advil Sudafed Midol Kaopectate Neosporin Pepto Bismol Zyrtek

Sunscreen

(over)

ADD any other medical information concerning medication, allergies, illness, etc. _____

ADD any dietary restrictions: _____

Parents/guardians of participants are advised that photographs or videotape of participants may be used in publications, websites or other materials produced from time to time by the Division of Youth and Young Adult Ministry or the Archdiocese of Baltimore. (Participants would not be identified, however, without specific written consent.)

Parents/guardians who do not wish their child(ren) to be photographed or filmed should so notify the Parish in writing. Please note that the Parish has no control over the use of photographs or film taken by media that may be covering the event in which your child(ren) participate(s).

Emergency Contact Number for Parent/Guardian _____ (you must have access to this phone number during the retreat)

Date_____ Parent/Guardian Signature _____

Date _____Parent/Guardian Signature _____

Child's Name _____

DYYAM 07-05-00