HOLY ROSARY TEEN ACTS RETREAT APPLICATION JUNE 13-16TH, 2024

Participant Name_____ Age (On June 13, 2024) ____ Birth Date_____

Gender ____ Cell # _____ School _____ Graduation Year _____

Participant Email _____ Parish _____

Address _____ City _____ Zip _____

T-Shirt Size _____

Parent/Guardian Name(s) _____

Home # _____ Cell # _____ Work # _____

Address _____ City _____ Zip _____

Parent Email _____

PLEASE MAIL COMPLETED PARENT/GUARDIAN CONSENT FORM AND MEDICAL CONSENT FORM WITH A $25 FEE TO:

Kathryn Robinson, 2636 Zimmerscheidt Rd. Alleyton, TX 78935

***NO HAND DELIVERED FORMS WILL BE ACCEPTED. THE FORMS MAY NOT BE POSTMARKED BEFORE WEDNESDAY, MAY 1ST, 2024.*

***THE $25 IS PART OF THE ENTIRE FEE OF $100. THE REMAINDER OF THE FEE IS DUE ON OR BEFORE THURSDAY, JUNE 13TH DURING REGISTRATION.*

***IF YOU ARE NOT ACCEPTED OR HAVE TO CANCEL, THE 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. Please no short shorts or open/loose tops. Remember that you will be going to mass each day and your attire should be appropriate. Shorts are acceptable.

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

Parental/Guardian Consent Form and Liability Waiver
St. Roch Catholic Church, Mentz, Texas
Teen ACTS Retreat

Minor Participant's Name: _____
Age: _____ Birth Date: _____ Sex: _____ Grade: _____
E-Mail: _____
School: _____
Parish: _____
Home Address: _____
Home Phone: _____ Cell Phone: _____

Parent/Guardian's Name:_____
Home Address:_____
Home Phone:_____ Cell Phone:_____
Work Phone:_____

I, _____, grant permission for my child, _____, to participate in this parish youth ministry event that requires transportation to a location away from the parish site. This activity will take place under the guidance and direction of adults from the Victoria Diocese. A brief description of the activity follows:

- **Type of event:** Teen ACTS Retreat
- **Date of event:** June 13-16, 2024
- **Cost:** $100.00 ($25.00 registration fee, remaining fee due before retreat)
- **Destination of event:** Cathedral Oaks Retreat Center
- **Individual in charge:** Kathryn Robinson
- **Estimated time of departure:** June 13, 2024 at 5:30pm
- **Estimated time of return:** June 16, 2024 at 10:00am
- **Activities:** Interaction with youth and adults concerning religious, spiritual, moral and social issues; prayer and scripture sharing.

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 child named herein, our heirs, successors and assigns to hold harmless and defend Sacred Heart Parish Catholic Church, its officers directors, and agents, and the Diocese of Victoria from any and all liability for illness, injury or death arising from or in connection with my child attending the above named event and I agree to compensate the parish, its officers, directors and agents and the Diocese of Victoria, or representative associated with the event for reasonable attorney's fees and expenses arising in connection therewith.

_____ _____

Signature Parent or Guardian **Date**

MEDICAL CONSENT AND PERMISSION TO TREAT

To the best of my knowledge, my child, _____, is in good health, and I assume all responsibility for the health of my child.
Emergency Medical Treatments: In the event of an emergency, I hereby grant permission to transport my child to a hospital for emergency medical treatment._____**YES** _____**NO**
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: (_____) _____

If you are unable to reach me, please contact:
Name:_____
Relationship to me or my child:_____
Home Phone: (_____)_____ Business Phone: (_____) _____
Cell Phone: (_____) _____

Family Doctor:_____
Phone Number: (_____) _____

Please include a photocopy of your Insurance Card (front and back).

- Insurance Carrier:_____ Policy Number_____
- My child is taking medication and will bring all medication with him/her. It will be clearly labeled. My child is taking the following medication(s) and directions for taking this medication, including dosage, frequency and storage are as follows:_____
  _____
- I hereby grant permission for non-prescription medication (such as cough drops, cough syrup, Tylenol, etc.) to be given to my child if necessary:_____**YES** _____**NO**
- I understand that aspirin will not be given to my child without my express permission. I hereby grant such permission:_____**YES** _____**NO**
- My child is allergic to the following (medications, foods, plants, insects…etc.)_____
- My child's immunizations are current and up to date:_____**YES** _____**NO**
- My child's last tetanus/diphtheria immunization: _____
- My child has the following physical limitations: _____
- My child experiences homesickness, emotional reactions to new situations, sleepwalking, fainting, bed wetting, etc. _____**YES** _____**NO**. If Yes, please explain:_____
  _____
- My child 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 child 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:_____
  _____
- Any additional information: _____

_____ _____
Signature of Parent or Guardian **Date**