St. Anne Parish
2016 Vital Signs Discipleship Confirmation Retreat

Friday, February 19th, 4:30 PM Through Sunday, February 21st, 2:00 PM 2016
Spencer Lake Christian Center, Waupaca, WI

Registration Fee: $100 (see below for payment details)
Includes: Lodging, food, transportation, retreat materials and chaperone support for the entire weekend

This form is Due: No later than Sunday, November 1st, 2015

Individual Youth Contact Information (One form per person ONLY!!)

Youth's Last Name: _____ Youth's First Name: _____

Date of Birth: _____ _____ Age: _____ Male ____ Female ____ Graduation Year: _____

Address: _____

City: _____ State: _____ Zip:_____

Phone #: _____ (H) E-mail Address: _____

Mother's name: _____ Phone: _____ (H) _____ (W) _____ (C)

Father's name:_____ Phone: _____ (H) _____ (W) _____ (C)

Intention to Participate:

_____My son/daughter **will** participate in this retreat weekend _____

_____This retreat weekend **does not** work with my son's/daughter's schedule for the following reasons…

_____

_____

…Please Contact us to arrange other retreat options

Payment:

Please make checks payable to "St. Anne Parish"

_____**The Full** $100.00 Participant payment is attached/enclosed

_____I would like to create a payment plan, please bill me (Payment due in full by January 15, 2016)

OFFICE USE ONLY

Date Received:_____ **Total Fees**: _____

Payment date: _____ Amt. Pd: _____Ck#: _____Balance:_____

Payment date: _____ Amt. Pd: _____Ck#: _____Balance:_____

Please Complete the Permission Form, Code of Conduct and Medical Information on the Following Pages

Church of St. Anne/Diocese of La Crosse Child Comprehensive Medical Release & Permission Form

Be sure to fill out this form COMPLETELY

Parental/Guardian Consent and Liability for Minors

I, _____, grant permission for my child, _____
Parent or guardian's name **Child's name**
to participate in this diocesan/parish event that requires transportation to a location away from the parish site. This activity will take place under the guidance and direction of diocesan/parish employees and/or volunteers from **St. Anne Parish** .

A brief description of the activity follows:

Type of activity: **Vital Signs Confirmation Retreat**
Individual in Charge: **John Schmitt, Director of Faith Formation**
Date(s) of event: **February 19th-21st, 2016**
Estimated time of departure and return: **Depart: 4:30 PM, Friday, February 19th, 2016**
Return:2:00 PM, Sunday February 21st, 2016
Mode of transportation to and from activity: **School Bus**
Individual Cost: **$100.00 per youth**

As 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, or our heirs, successors, and assigns, to hold harmless and defend St. Anne Parish , its officers, directors, employees and agents, and the Diocese of La
Name of Parish
Crosse, its employees and agents, chaperones, or representatives associated with the event, from any claim arising from or in connection with my child attending the event or in connection therewith, and I agree to compensate the parish, its officers, directors and agents, and the Diocese of La Crosse, its employees and agents and chaperones, or representative associated with the event for reasonable attorney's fees and expenses which may incur in any action brought against them as a result of such injury or damage, unless such claim arises from the negligence of the parish/diocese.

Initials of Parent Guardian: _____ Date: _____

Emergency Contact Information

Emergency Contact: _____ Relationship: _____

Phone: _____ (H) _____(W) _____ (C)

Physician: _____ Clinic/Hospital: _____ Office Phone: _____

Medical Insurance Company: _____ Policy #:_____

Code of Conduct

We expect each participant to conform to these rules of conduct:

- No possession or use of alcohol, drugs, tobacco, or pornography.
- No fighting, weapons, fireworks, lighters, or explosives.
- No offensive or immodest clothing.
- No student may drive.
- No males in female sleeping quarters, and no females in male sleeping quarters.
- Participation with the group is expected.
- Respect property.
- Respect one another, staff, and leaders.
- Respect and comply with event schedules and with any other specific event rules established by leaders.
- **Students who fail to comply with these expectations may be sent home at their parents' expense.**

I, the student, have read the rules of conduct, the above evaluation of my health, and permission to participate in youth group activities. I agree to abide by the stated personal limitations and code of conduct.
Initials of Student: _____ Date: _____
Initials of Parent Guardian: _____ Date: _____

Permission to Use Participant Photos

You have my permission to use said participant's photos for commercial purposes (ex: advertising this event in flyers, on the web, etc.).

Initials of Student:_____Date: _____

Initials of Parent Guardian:_____Date: _____

Medical Treatment

Emergency Medical Treatment: In the event of an emergency, I hereby give permission to transport my child to a hospital for emergency medical or surgical treatment at my expense. I wish to be advised prior to any further treatment by the hospital or doctor. In the event that you are unable to reach me, such treatment may be administered if deemed necessary. In the event of an emergency, if you are unable to reach me at the numbers given above, please contact the emergency contact listed above.

Initials of Parent Guardian: _____ Date: _____

Other Medical Treatment: In the event it comes to the attention of the parish, its officers, directors and agents, and the Diocese of La Crosse, chaperones, or representatives associated with the activity that my child becomes ill with symptoms such as headache, vomiting, sore throat, fever, diarrhea, I want to be called collect (with phone charges reversed to myself).

Initials of Parent Guardian: _____ Date: _____

Medications: My child is taking medication at present. My child will bring all such medications necessary, and such medications will be well labeled. Names of medications and concise directions for seeing that the child takes such medications, including dosage and frequency of dosage, are as follows:_____
_____

Initials of Parent Guardian: _____ Date: _____

Medication Options

No medication 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.
Initials of Parent Guardian: _____
Date: _____

OR

I hereby grant permission for non-prescription medication (such as aspirin products, i.e. acetaminophen or ibuprofen, throat lozenges, cough syrup) to be given to my child if deemed appropriate.
Initials of Parent Guardian: _____
Date: _____

Medical History

If necessary, describe in detail the nature and severity of any physical and/or psychological ailment, illness, propensity, weakness, limitation, handicap, disability, or condition to which the participant is subject and of which the staff should be aware, and what, if any action of protection is required on account thereof. Submit this notification in writing and attach it to this form. Include names of medications and dosages that must be taken. The parish/Diocese of La Crosse will take reasonable care to see that the following information will be held in confidence. Some activities may be physically strenuous (especially mission trips and camps). If you desire to limit a participant's participation in any way, please submit your wishes in writing prior to the trip.

1. Is the participant in good health and able to participate in normal activities? ____Yes ____No
   If not, please submit a statement indicating limitations and/or restrictions.
2. Please give the date of the participant's most recent physical examination: _____
3. Immunization History (Please give dates)
   Date of last Tetanus Shot: _____ *Please fill in below only for foreign mission trips:*
   DPT _____ DPT Booster _____ Polio Booster _____ Polio Series _____
   Other, if any necessary, for specific trip: _____
   *Note: You are responsible for consulting your doctor about immunizations necessary for foreign missions.
4. Allergies
   Pollens _____ Medications _____ Food _____ Insect bites _____
   Please note specifics: _____
5. Has the participant ever suffered from or been treated for any of the following:
   Asthma_____ Epilepsy/seizure disorder _____ Heart trouble _____
   Diabetes _____ Frequently upset stomach _____ Physical handicap _____
   Depression _____ Emotional/Mental Disorder _____ Other _____
6. Operations, serious injuries, or major illnesses in the past year: _____
   _____ Dates: _____
7. Is the participant subject to chronic homesickness, emotional reactions to new situations (sleepwalking, bedwetting, fainting)? _____
8. Has the participant recently been exposed to contagious disease or conditions, such as mumps, measles, chickenpox, etc.? If so, list date and disease or condition: _____
   _____
9. Does the participant have a medically prescribed diet? ____Yes ____No
10. The participant is a ____swimmer ____non-swimmer

Statement of Truth and Accuracy

I hereby certify that all of these statements are true and accurate to the best of my knowledge.
Signature of Parent/Guardian: _____ Date: _____
Signature of Student: _____ Date: _____