QUO VADIS DAYS

RETREAT

The Lord made you for a reason. He didn't want this world to exist without you, and from the moment you were conceived, He has had a plan for your life. Quo Vadis Days is to help you discover that plan.

Young men entering, in, or just graduated from high school are invited to attend the Second Annual **Quo Vadis Days** Retreat. Spend time with other young men your age looking at the Lord's call in your life while having fun. **QVD** is led by priests and seminarians of the diocese and is supported by the Diocesan Office of Vocations. **QVD** will be held from **July 13-16** at the Bishop Connare Center in Greensburg. The cost of the camp is $50 and scholarships are available. *See reverse for more details.*

JULY 13-16, 2014 | **BISHOP CONNARE CENTER** | **GREENSBURG**

PGHPRIEST.COM

Quo Vadis Days

Diocese of Pittsburgh
July 13-16, 2014
Bishop Connare Center, Greensburg

Please send this registration form, the image waiver, your permission form and your QV fee to:
St. Paul Seminary, c/o Fr. Joe Freedy, 2900 Noblestown Road, Pittsburgh, PA 15205
Please make checks payable to: Diocese of Pittsburgh

REGISTRATION FORM

PLEASE PRINT NEATLY

Name:	Parish:
Grade: 9 – 10 – 11 – 12 (entering)	School:
Age:	T-Shirt Size: S – M – L – XL - XXL
Street:	City: Zip:
Home Phone:	Cell Phone:
Email:	Parents Email:
Parent(s) Name:	Parent(s) Cell Phone:
Emergency Contact:	Emergency phone:
Special dietary needs/allergies:	

FOR QV USE – Please do not write below this line

- ☐ Permission Slip ☐ Image waiver
- ☐ Registration Fee/Scholarship
- ☐ Room assignment: _____
- ☐ Team:

QUO VADIS DAYS

July 13-16, 2014 † Bishop Connare Center, Greensburg

_____ ____ (M) F

NAME AGE SEX

_____(_____)_____

ADDRESS CITY STATE ZIP PHONE

SCHOOL GRADE BIRTHDATE PARISH

TEEN EMAIL ADDRESS PARENT/FAMILY EMAIL

PERMISSION

I/we, the parents or guardians of the above mentioned child, for myself/ourselves and for my/our child, give permission for my/our child to participate in the above mentioned event on July 13-16, 2014

MEDICAL AUTHORIZATION

In the event of any injury or illness to my/our child during his/her participation in this program, I/we hereby give my/our permission for the necessary medical treatment to be given to my/our child. I/we, for myself/ourselves, for my/our child, our respective heirs, and my/our respective legal representatives, do hereby indemnify and hold harmless any representative of the Roman Catholic Diocese of Pittsburgh and from any and all claims, demands, and courses of action of whatever kind and nature for their actions taken pursuant to this authority.

I/we agree that in case of injury to my/our child, I/we will apply my/our hospitalization and/or accident insurance toward payment of the expenses incurred and will not look to the Roman Catholic Diocese of Pittsburgh for payment of any medical costs or injury related costs.

_____ _____

Parent/Guardian Signature Parent/Guardian **Cell** Phone Number

_____ _____

Insurance Company Policy Number

_____

Name and Phone Number of Person if parent/guardian is not available

TO BE ACCEPTED, BOTH SIDES OF THIS FORM MUST BE COMPLETELY FILLED OUT!

OVER>>

CONSENT TO TREAT

I/we the undersigned parent(s)/guardian(s) of _____
hereby authorize treatment of my/our child by a licensed medical physician in case of any accident or illness that may so arise, or any hospitalization necessary.

_____ OR _____
Father/Legal Guardian Signature Mother/Legal Guardians Signature

Today's Date _____ This consent form will remain in effect until July 16, 2014

Medical Matters: I hereby warrant that to the best of my knowledge, my child is in good health, and I assume all responsibility for health of my child. Of the following statements pertaining to medical matters, **sign only those in accordance with your wishes**.

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

_____

_____

Signature: _____ Date: _____

2.) Over the counter medications: I hereby grant permission for non-prescription medication (such as Tylenol, throat lozenges, cough syrup, etc.) to be given to my child, if deemed advisable.

Signature: _____ Date: _____

3.) No medication. No medication of any type whether prescription or non-prescription medication may be administered to my child unless the situation is life threatening and emergency treatment is required.

Signature: _____ Date: _____

Any known allergies to food or medications? _____

Any physical limitations? _____

Any dietary needs? (For example: Let us know if you are diabetic, vegetarian, etc.)

_____

Is the child subject to chronic homesickness, emotional reactions to new situations, sleepwalking, or fainting? ☐YES ☐NO

If yes, please explain. _____

TO BE ACCEPTED, BOTH SIDES OF THIS FORM MUST BE COMPLETELY FILLED OUT!

OVER>>

Diocese of Pittsburgh - Office of Priestly Vocations
2900 Noblestown Road
Pittsburgh, PA 15205
(412) 456-3000 ext. 3612
jfreedy@diopitt.org

Waiver/Photograph Release:

I authorize the Office of Priestly Vocations to use photos, and or other likeness' of myself and or my child or the child for whom I have legal guardianship for any promotional materials regarding Office of Priestly Vocations programs, facilities, or services.

Such likeness' will not be sold to other parties. Promotional materials bearing these likenesses may be distributed for free to the public and posted on the Office of Priestly Vocations website.

The Office of Priestly Vocations reserves the right to use any photo or likeness for a time period beginning when this form is signed and ending upon written request of participant, parent or legal guardian.

Participant's Name, printed: _____

Participant's Signature: _____ Date_____

Parent's Signature:_____ Date_____

(If participant under18 years of age)