ACTIVITY PERMISSION & EMERGENCY FORM
YOUTH ACTIVITY PROGRAM

Child's First Name_____ **Last Name** _____

I allow my child to participate in the activity below:

Event:	**Camp Trinity Teen Retreat**
Date:	**September 22-24, 2017**
Location:	**Shrine Mont – Bear Wallow Camp**
Emergency Contact Numbers	On Site Number

Acknowledgement

I know that all possible care and safety will be provided for my child during the above-named activity. Therefore, in granting my permission, I release from all liability and waive all claims against Holy Trinity Catholic Church, church staff, and church volunteers for any harm to my child that may occur during this activity, including but not limited to accident, injury, illness, or property loss. I understand that I must pick up my child at the time indicated.

_____ _____

Print – Parent/Guardian Name **Signature – Parent/Guardian**

CONTACT INFORMATION FOR RETREAT WEEKEND			
Mother/	**Home:**	**Father/**	**Home:**
Guardian	**Cell:**	**Guardian**	**Cell:**

PARTICIPANT BEHAVIOR COVENANT - SIGNATURE REQUIRED

I understand that I must behave in a manner worthy of my parents and me. If I violate the trust placed in me, my parents will pick me up.

_____ _____

Signature of Youth Participant **Date**

AUTHORIZATION TO PUBLISH PICTURES

I grant permission to Holy Trinity Catholic Church to publish pictures of my child on the church's web site or in the church's publicity information, newsletters, bulletins or other printed material. I further state that I have the right to grant or refuse this permission, as I am the child's parent/legal guardian. -

❑ YES
❑ NO

Initials: ____

Health Form & Emergency Medical Release Form

This information remains confidential and will be destroyed at the end of the year.

Child's Name:-		**Gender:**	**M**	**F**	**Birth date:**	
Address:						
City:		**State:**			**Zip:**	

Health Insurance:		**I D #:**	
Policy Number:		**Group I D#:**	

Environmental allergies, allergic to bees, other chronic conditions, recent or current illness or injury?

Please list any medications that your teen is bringing with them:

OTC Medication: The following may be dispensed to my child (as prescribed by the product label).

Circle all that apply:	**Tylenol**	**Ibuprofen**	**Aspirin**	**Benedryl**	**Other:**

IMMUNIZATIONS & TB. Are the following immunizations/test current to this school year?

Childhood Immunizations? ❑ **YES** ❑ **NO**	**Tetanus Shot?** ❑ **YES** ❑ **NO**
TB? ❑ **YES** ❑ **NO**	

EMERGENCY MEDICAL TREATMENT RELEASE

In the event of an emergency, I give permission to transport my child to a hospital for emergency medical treatment. I wish to be advised prior to any further treatment by the hospital or doctor.

Signature of parent/guardian **Date**

ALTERNATE CONTACT: In the event of an emergency, please contact the following:

Name:			
Relationship to child:			
Home Phone:		**Cell Phone:**	