

**ST. BEDE THE VENERABLE YOUTH MINISTRY
2010 YOUTH RETREAT ~ FEB. 12-14TH, 2010**

Location: Mt. Manresa Retreat Center, Staten Island, NY

Parent Permission Form

Please print clearly

Name _____ Birth date _____

Address _____

Home Phone Number _____

Mother's Daytime/Cell Phone _____

Father's Daytime/Cell Phone _____

Emergency Contact (*someone other than a parent*)

Contact Persons Name _____

Relationship _____

Phone/Cell # _____

Parent Permission

I/we hereby give my child _____ permission to participate in the Youth Retreat Program directed by the Youth Ministry of St. Bede the Venerable Parish. I give my child permission to use the transportation supplied by St. Bedes to and from the retreat. I understand that this program is under adult supervision and that reasonable efforts will be made to minimize risk or injury to participants. I agree and understand that we assume the risks inherent in the trip, and with full knowledge of the risks, I/we agree to hold harmless and release St. Bede the Venerable Church, its principal agents, the Archdiocese of Philadelphia, their employees, representatives and volunteers from claims, all responsibility and liability of any nature whatsoever for any damages, injuries, or other losses arising or related my child's participation in or transportation to and from the retreat. I/we understand my child's responsibilities in being part of this retreat group and will support him/her in any way that I/we can.

Parent's Signature _____ date _____

Parent's Signature _____ date _____

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MEDICAL RELEASE FORM

Please print clearly and be specific

Name _____

Date of last Tetanus shot _____

Medications student can NOT take _____

Current medications being taken _____

Allergies and special medical conditions (ex. Latex allergy, bee and/or insect stings)

Special dietary requirements, food allergies, vegetarian, etc _____

Insurance

Health Insurance Company/Hospitalization Plan _____

Policy Number: _____ Phone Number _____

Policy Holder's Name & identification number: _____

Medical Information

Family Physician _____ Phone Number _____

My child requires the following medicine: _____ Frequency _____

My child has permission to be given Tylenol or Ibuprofen if requested Y N

In case of Medical Emergency, I understand that in the event if medical treatment is required, every effort will be made to contact me or the emergency contact person. However, if I cannot be reached, I give permission to the staff to secure the services of a licensed physician to provide the care necessary, including hospitalization, anesthesia, injection, or surgery for my child's well-being.

Signature of Parent/guardian X _____ Date _____