

Confirmation Retreat
Extended Field Trip – Long Form
PARENT/LEGAL GUARDIAN
PERMISSION AND INDEMNITY AGREEMENT

Name of Son/Daughter/Ward: _____

Parish/School: Divine Savior

Designated Supervisor of Activity: Terri Riesselmann, Joe Watry, Bill Johannes

Activity: Confirmation Retreat

Location: Holy Hill Basilica 1525 Carmel Rd. Hubertus, WI 53033

Date(s), Time and place of Activity: 6:00pm April 2nd -noon April 4th 2027

Method of Transportation: Supervisors will bring to retreat and parents will pick up from the retreat

Student Cost: \$140

Deadline: March 10th, 2027

I consent to the participation of my SON/DAUGHTER/WARD in the above-named ACTIVITY. In consideration for my SON/DAUGHTER/WARD's participation, I agree to reimburse and indemnify the PARISH/SCHOOL (understood to include the Archdiocese of Milwaukee) for all reasonable legal and court fees incurred by PARISH/SCHOOL in defending a lawsuit that I or my SON/DAUGHTER/WARD may bring against the PARISH/SCHOOL which relates to the above-named ACTIVITY if the PARISH/SCHOOL is found not legally liable by the courts and prevails in the lawsuit. If the PARISH/SCHOOL is found legally liable for injuries sustained by SON/DAUGHTER/WARD, this paragraph will not apply.

I certify that I understand this agreement and any risks and hazards associated with the ACTIVITY described above that my SON/DAUGHTER/WARD will be participating in. I further understand that I had the opportunity to fully discuss this agreement with a representative of the PARISH/SCHOOL to clarify any concerns of questions about the ACTIVITY or this agreement that I may have had.

PARENT/GUARDIAN'S NAME(S): _____

HOME ADDRESS: _____

HOME PHONE: (____) _____ BUSINESS PHONE (____) _____

Signature _____ Date _____

OPTIONAL: If different from above or reverse side:

ANOTHER PARENT/GUARDIAN'S NAME: _____

OTHER HOME ADDRESS: _____

HOME PHONE: (____) _____ BUSINESS PHONE (____) _____

The other side of this form must be filled out and signed.

MEDICAL RELEASE FORM

PARTICIPANT'S NAME: _____ BIRTH DATE: _____ SEX: _____
FAMILY DOCTOR: _____ PHONE: (____) _____
Family Health Plan Carrier: _____ Policy Number: _____

MEDICAL MATTERS: I hereby warrant to the best of my knowledge, my child is in good health, and I assume all responsibility for the health of my child. OF THE FOLLOWING STATEMENTS pertaining to medical matters. SIGN ONLY THOSE IN ACCORDANCE WITH YOUR WISHES.

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. I wish to be advised prior to any further treatment by the hospital or doctor. In the event of an emergency, if you are unable to reach me at the above numbers, contact:

NAME & RELATIONSHIP: _____
HOME PHONE: (____) _____ BUSINESS PHONE: (____) _____
Signature _____ Date _____

Medications: SON/DAUGHTER/WARD is taking medications at present and will bring all such medications necessary, and such medications will be well-labeled. I give permission for SON/DAUGHTER/WARD to take this medication on his/her own. The dosage and frequency of dosage is as follows:

Signature _____ Date _____

If requested, I DO give permission for SON/DAUGHTER/WARD to be given the following (circle):

Aspirin Benedryl cream Cough Syrup/drops Ibuprofen Pepto Bismol Alka Seltzer
Tylenol Tums Sudafed **Any of the Above** _____

Signature _____ Date _____

No Medication of Any Type: whether prescription or nonprescription may be administered to my SON/DAUGHTER/WARD unless the situation is life threatening and emergency treatment is required.

Signature _____ Date _____

You should be aware to these special medical conditions of my child: _____

Signature _____ Date _____