Archdiocese of Milwaukee
Youth Permission and Indemnity Agreement

Name of Participant: _____

Parish/School: St. Katharine Drexel Parish

Designated Supervisor of Activity: Director of Youth and Young Adult Ministry-John Pryme

Activity: Confirmation Retreat

Description of Activity: Retreat for Candidates at Mt. Tabor Center, Menasha

Date(s) and Time of Activity: 4pm: Saturday, December 15th- 3pm: Sunday, December 16th, 2018

Method of Transportation: Bus

Cost: N/A Registration Deadline: September 23rd, 2018

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 have an understanding of 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 Name(s): _____

Home Address: _____

Home Phone: (_____)_____ Business Phone (_____)_____

Cell Phone: (_____)_____ E-mail: _____

Signature_____ Date _____

OPTIONAL: If different from above or reverse side:

Parent/Guardian Name(s): _____

Home Address: _____

Home Phone: (_____)_____ Business Phone (_____)_____

Youth Medical Release Form

Participant's Name: _____

Birthdate (mm/dd/yy): _____ 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: _____

Other Medical Treatment: In the event it comes to the attention of DESIGNATED SPERVISOR or staff that SON/DAUGHTER/WARD becomes ill with symptoms of headache, vomiting, sore throat, fever, or diarrhea, I DO want to be called collect (with phone charges reversed to myself in necessary).

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	Midol	Ibuprofen	Pepto-Bismol	Cough drops
Aspercream	Tums	Sudafed	Primatene Mist	Tylenol	Other _____

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: _____

Specific Medical Information: The parish/school will take reasonable care to see that the following information will be held in confidence. **You should be aware of these special medical conditions of my child**:
Allergies to medications, foods, plants, etc. _____

Medically prescribed diet: _____

Currently being treated for mental health issues: _____

Other special medical conditions: _____