

GRADE 10 RETREAT

PARENTAL/GUARDIAN CONSENT FORM/ LIABILITY WAIVER

Participant's name _____ Birth date _____ Age: _____ Sex: _____
Street Address/City/State/Zip _____
Phone (home) _____ E-mail _____ Other _____
Parent/Guardian name _____ Work Phone _____ Other _____

I ask for and grant permission for my son/daughter _____ to participate in an event that requires transportation to a location away from the parish. This activity will take place under the guidance and direction of employees and volunteers from the **ARCHDIOCESE OF HARTFORD** and Midd-South Catholic Parish.

What: Holy Family Retreat

Where: Holy Family Passionist Retreat Center
West Hartford, CT

When: Sunday, April 28, 2024

Time of Event: 1:00pm - 7:00pm

Mode of Transportation: First Student Bus Company

Estimated travel time: 50 Minutes

Fee: \$50

Person in charge from parish: Ami Conlan

While youth are responsible for his/her own behavior, as parent and/or legal guardian, I remain legally liable for any actions or damages made by the above named minor. I am aware that I will be called if my teen breaks any of the rules and has to be sent home. I agree on behalf of myself, my teen named herein, our heirs, successors, and assigns to hold harmless and defend the **ARCHDIOCESE OF HARTFORD**, Midd-South Catholic Parish, its officers, directors, agents, employees, representatives associated with this event from any and all liability claims, loss or damage arising from or in connection with my teen attending this event or in connection with any illness or injury or cost of medical treatment in connection therewith, and I agree to compensate the above named parish, and the **ARCHDIOCESE OF HARTFORD**, its officers, directors, agents, employees, or representatives associated with the event for reasonable attorney fees and expenses arising in connection therewith.

I hereby warrant that to the best of my knowledge, my teen is in good health and I assume all responsibility for his/her health. In the event of an emergency and I can not be reached, I hereby give permission to transport my teen to a hospital or medical facility and to seek medical attention. I give permission for the administration of non-prescription medication - aspirin, throat lozenges or cough syrup - if deemed appropriate and if the situation is not life-threatening.

I also understand that my child may be photographed for future publicity (including, but not limited to Catholic Transcript/ORTV).

Emergency contact person: Name _____ Relationship _____ Phone _____
Hospital Preference: Name _____ (Town) _____
Doctor: Name _____ (Phone) _____
Insurance: Company _____ Employer _____ Group # _____
Subscriber Name _____ Subscriber # _____
Date of last tetanus shot _____
Medications currently taking: (name and dosage) _____
Allergies: (medication, foods, plants, insects) _____
You should also be aware of these special medical /physical/ mental conditions of my child (special diet, sleepwalking, fainting, nose bleeds, recent injuries, exposure to contagious diseases, etc.):

Print name _____ Signature _____ Date _____