PARENT/GUARDIAN PERMISSION FORM FOR SPRING RETREAT
Please Return by October 13, 2017

Dear Parent or Legal Guardian:

Your son/daughter is invited to participate in our parish/school Spring Retreat. This retreat, done in partnership with five other area parishes, will emphasize the unity of the Catholic Church and how we can use our gifts and talents to help ourselves and others. Details of this retreat are as follows:

Name of the Event: Unashamed - High School Youth Conference, Diocese of Lansing

Destination: Lansing Center, 333 E. Michigan Ave., Lansing, MI 48933

Cost: $35.00 (Our parish will cover the remainder)

Date and Time of Departure: Sunday, November 5, 2017.
Meet at St. Jude Youth Room at 9:15 am

Date and Anticipated Time of Return: Sunday, November 5, 2017 at 8:15 pm
Pick up is at St. Jude church.
Mass is included in the conference.

Method of Transportation: Adult Volunteers

Designated Supervisor of Activity: Hallie Card

Emergency Phone Number: Lansing Center (517) 483-7400; Hallie's Cell (517) 581-0203

For your child to participate in this event, please **complete, sign, and return this permission form by October 13, 2017. You may also drop off this form to the Parish Office.** As parent or legal guardian, you remain responsible for any legal responsibility which may result from actions taken by the named student. This section is for your information.

PERMISSION FORM FOR HIGH SCHOOL YOUTH CONFERENCE

I hereby consent to participation by my son/daughter, ______________________________________ for the High School Youth Conference on 11/5/17. I understand that this event will take place away from the parish/school grounds and that my son/daughter will be under the supervision of the authorized parish/school personnel on the stated dates. I consent to the stated conditions for participation in this event, including the method of transportation. I further understand that if my student chooses behavior that is inappropriate, I may be called to drive to the Lansing Center and pick him/her up.

________________________________ ________________________________ ____________
(print parent/guardian's name) (parent/guardian's signature) (date)

MEDICAL INFORMATION

My child is allergic to: ____

My child must take the following medication (indicate dosage, frequency, etc.):

Please note specific medical problems (use back if necessary): ______________________________

I grant permission for non-prescriptive medication (e.g. Tylenol, throat lozenges, cough syrup, or pepto-bismol); and routine nonsurgical medical care to be given to my child if deemed advisable by the supervising parish/school personnel. In case of an emergency, I also grant permission to transport my child to the nearest hospital for emergency medical or surgical treatment. I will be contacted as soon as possible and will be advised prior to any further treatment by the hospital or doctor.

Signature ____ Date _____________________

Emergency Phone Number to reach you during retreat: ___________________________________

If above person is unavailable, please notify: ____

HEALTH HISTORY AND MEDICAL RELEASE FORM
FOR PARISH PROGRAMS AND ACTIVITIES

Participant's Name__________________________ Sex _______ Birth Date _______ Age _____

Parent/Guardian ____________________________ Relationship to participant ______________

Street Address _________________________City ____________ State _____ Zip Code _______

Home Telephone ( ) ____________________ Work Telephone ( ) _______________________

HEALTH HISTORY

Family Doctor __________________________ Telephone Number ( ) ____________________

IMMUNIZATIONS (Record YEAR of last immunization or last time person had disease):

Tetanus/Diphtheria _____ Measles _____ Mumps _____

Chicken Pox _____ Rubella _____ Polio _____

TB _____(results) _______ Hepatitis B _____ Other _____

SPECIAL INFORMATION: (Please check all that apply. Information will be held in strict confidence.)

Sleep Walking _____ Fainting _____ Dizziness _____

Blackouts _____ Asthma _____ Kidney Problems _____

Frequent Nosebleeds _____ Frequent Colds _____ Seizures _____

Severe Headaches _____ Diabetes _____ Severe Homesickness _____

Frequent Earaches _____

ALLERGIC REACTIONS (Please list all known allergies - plant, insect, food, medicine AND TYPE OF REACTION):

____

Please indicate any other medical problems/situations pertinent to your child:

____

Any physical limitations? _____ If yes, explain ____

Any emotional/psychological limitations or reactions to be aware of? ____ If yes, explain:

____

Is the student presently taking any medication? ________ All medication is to be well labeled with clear, concise directions indicated here (frequently, dosage, etc.):

____

In an **EMERGENCY,** and if unable to reach parent/guardian, we should contact:

1. Name _______________________________ Telephone Number ( ) _________________________

2. Name _______________________________ Telephone Number ( ) _________________________

PLEASE FILL OUT BOTH SIDES

Note to parent/guardian: Please read the following sections carefully. We apologize for the complexity but we must be sure we have your full consent in these areas as well as, having this document notarized.

PERMISSION FOR ROUTINE MEDICAL TREATMENT

All attempts **will** be made to notify you if your child requires medical treatment (i.e., cases of high, persistent fever; severe vomiting, etc.). Please indicate whether or not you wish attempts to be made to contact you if your child becomes ill with minor symptoms (i.e., headache, sore throat, low-grade fever, etc.). **YES** _____ **NO** _____
NOTE: If you do wish to be contacted and it is not a local call, the charges shall be reversed to you.

We do not wish to give any medical treatment to your son/daughter against your wishes or family practice. Please read each of the following statements carefully and **sign only either A or B** which is in accord with your wishes:

A) I grant permission for non-prescription medication (i.e., Tylenol, cough syrup, etc.) except for the following ___________________________ to my student if deemed advisable by the designated supervisor, and I grant permission for routine non-surgical medical care to be given to my student, if deemed advisable by the designated supervisor(s).

* SIGNATURE _____________________________________ DATE _________________

or

B) I do not want **ANY** type of medication administered to my child unless the situation is life-threatening and emergency treatment is required.

* SIGNATURE _____________________________________ DATE _________________

PERMISSION FOR EMERGENCY MEDICAL TREATMENT

In case of emergency, I hereby give permission to transport my child to the nearest hospital/emergency center for emergency medical or surgical treatment. I will be contacted as soon as possible and will be advised prior to any further treatment by the hospital or doctor.

* SIGNATURE _____________________________________ DATE _________________

FAMILY INSURANCE PROVIDER/HEALTH PLAN ___________________________
HEALTH PLAN NUMBER (Include expiration date): ____________________________

Revised August 2014