# Church of St. Raphael – Crystal, MN
# Confirmation Retreat 2018-2019 – Koinonia Retreat Center – Annandale MN
## PARENTAL CONSENT FORM & INDEMNITY AGREEMENT

Student/Participant Name: _____

Date of Birth: ___/___/___ Sex: M / F School: _____ Grade: ____

Parent/Guardian Name _____

Home Address _____

Home Phone _____ Cell Phone _____

Email: _____

Date of Event/Field Trip: **October 12-14, 2018**
Type of Field Trip: **St Raphael Confirmation Retreat**
Destination: **Koinonia Retreat Center - Annandale, MN**
Cost: **$150.00**
Individual(s) in Charge: **Anna Scherber / Josh Stegman**
Time: **5:00 pm on Friday through 3:00 PM on Sunday**

I, _____, grant permission for _____
Parent or Guardian Name Child Name

to participate in the above named activity and I warrant that my child is in good health. In consideration of my child's participation, I agree to indemnify the *Church of St. Raphael and the Archdiocese of St. Paul & Minneapolis* from any claims or law suits brought against the *Church of St. Raphael and the Archdiocese of St. Paul & Minneapolis* by myself, my child or others, that arises out of any behavior by my child at the event/activity described above. I also agree to pay reasonable attorney's fees or expenses incurred by the *Church of St. Raphael and the Archdiocese of St. Paul & Minneapolis* in defense of such a claim/suit. Should photos or video be taken, I give my permission for the use of my child's image and /or likeness in any promotional or other marketing activities relating to the youth ministry programs of *Church of St. Raphael*.

**EMERGENCY MEDICAL TREATMENT**: In the event of an emergency, I give permission to transport my child to a hospital for medical treatment. I wish to be advised prior to any further treatment by a doctor or hospital. In the event of any emergency, if you are unable to reach me at the above numbers, contact

_____ _____
Name Emergency Phone Number

## MEDICAL INFORMATION:

Medication my child is taking at present _____
Family Health Plan carrier number _____
Family Doctor _____ Phone Number _____

As Parent or Guardian, I agree to all of the above stated considerations and conditions.

_____ _____
Parental Signature Date

**MEDICAL MATTERS**: I hereby warrant that 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 that are applicable.)**

**Medical Treatment**: In the event it comes to the attention of the Church of St. Raphael its officers, directors and agents, and the Archdiocese of Saint Paul & Minneapolis, chaperons, or representatives associated with the activity that my child becomes ill with symptoms such as headache, vomiting, sore throat, fever, diarrhea, I want to be called.

Signature: _____ Date: _____

**Medications**: My child is taking medication at present. My child will bring all such medications necessary, and such medications will be well-labeled. Names of medications and concise directions for seeing that the child takes such medications, including dosage and frequency of dosage, are indicated on attached **Prescription Drug & Medical Authorization Form.**

Signature: _____ Date: _____

**No medication** of any type, whether prescription or non-prescription, may be administered to my child unless the situation is life-threatening and emergency treatment is required.

Signature: _____ Date: _____

I hereby grant permission for **non-prescription medication** (such as non-aspirin products, i.e. acetaminophen or ibuprofen, throat lozenges, cough syrup) to be given to my child, if deemed appropriate.

Signature: _____ Date: _____

**Specific Medical Information**: Church of St. Raphael will take reasonable care to see that the following information will be held in confidence.

Allergic reactions (medications, foods, plants, insects, etc.): _____

Immunizations: Date of last tetanus/diphtheria immunization:_____

Does child have a medically prescribed diet? _____

Any physical limitations? _____

Has child recently been exposed to contagious disease or conditions, such as mumps, measles, chickenpox, etc.? If so, date and disease or condition:_____

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

## CODE OF CONDUCT

The following are a few rules that all participants are expected to follow while participating and representing *Church of St. Raphael* in this event sponsored by *Church of St. Raphael* on Oct. 12-14, 2018.

***Please read and sign.***

**I, _____, WILL:**
**Printed Name of Youth Participant**

- Treat all other persons with respect and not cause any intentional harm (physically, emotionally, or spiritually) to any person in any way.
- Respect the property of others, including all program facilities and property.
- Follow all appropriate instructions of all personnel aiding in this event, including, but not limited to, chaperones, support staff, transportation personnel and administration.
- Be on time for all check-ins and departure time.
- Not have in my possession any tobacco, alcohol or any controlled illegal substance

I agree that if any of these terms are violated, *Church of St. Raphael* can send the participant home at the participant/guardian's expense.

_____ _____
Youth Participant Signature Date

_____ _____
Parent/Guardian Signature Date

**Please return this form/donation to the**
**St. Raphael Youth Ministry Office**
**7301 Bass Lake Road**
**Crystal, MN 55428**
**by: <u>September 28, 2018</u>**

# CHURCH OF ST. RAPHAEL

## PRESCRIPTION DRUG AND MEDICINE AUTHORIZATIONS

**(USE THIS FORM ONLY IF MEDICATION IS TO BE GIVEN DURING THE EVENT)**

**The following information must be completed before medicine is given.**

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Student Name_____

Name of Prescription/Medicine _____

Prescribing Doctor _____

Amount of Dosage _____

Times to be Given _____

Duration of Prescription _____

**I, _____, herby authorize St. Raphael Chaperones to**
Parent/Guardian

**dispense medicine to _____ as directed above.**
Student

_____ _____

Signature of Parent/Guardian Date