ROCK Retreat Registration Form

July 10th – July 13th 2017

One form per child registered please

Fee:

$50 per child

Registration Deadline:

June 10th

Please Make Checks Payable to:
St. Peter Parish
128 E 19th Avenue
Covington, LA 70433

Event Description:

All 5th – 7th graders are welcome to join ROCK's Mission Retreat for a week for fun, fellowship, and spiritual growth focused on the missionary spirituality of the Church.

Child's Name: _____

Age _____

T-shirt Size: _____

Parent(s) name(s)

_____

Parent(s) phone number _____ - _____ - _____

MEDICAL INFORMATION AND CONSENT FORM

GENERAL INSTRUCTIONS TO PARENTS/GUARDIANS/ADULTS:

1. Please take care in filling out this form. It provides crucial information for caregivers in the event of illness or medical emergency. Accuracy and thoroughness are encouraged.
2. **Sections I, II and V are <u>mandatory</u>**. Sections III and IV provide you with treatment options in non-emergency situations.

CHILD or **ADULT** *(choose one):*_____Parent/Guardian's name: _____

Participant's Birth date: _____ Sex:_____ E-Mail _____

Home address: _____
(Street) (City/State) (Zip)

Home phone: _____Cell phone: _____Business phone: _____

<u>SECTION I.</u> **<u>MEDICAL MATTERS</u>**

As the **PARENT / LEGAL GUARDIAN / ADULT** *(choose one)* who is currently associated with **St. Peter Youth Ministry,** I hereby authorize **Rafael Flores** or his/her assistants to carry out the wishes I have named (herein) in areas of emergency medical treatment and other cases of illness. This authorization inclusively extends from **July 10, 2017, through July 13, 2017.** I hereby warrant that, to the best of my knowledge, said person is in good health, and I assume all responsibility for the health of said person.

Signature: _____ Today's Date:_____

<u>SECTION II.</u> **<u>EMERGENCY MEDICAL TREATMENT</u>**

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 numbers listed herein, contact:

Name & relationship: _____Phone: _____

Family doctor: _____ Phone: _____

Family Health Plan Carrier: _____Policy #: _____

Signature: _____ Date: _____

<u>SECTION III:</u> **<u>OTHER MEDICAL TREATMENT</u>**

In the event it comes to the attention of the parish, its officers, directors and agents, and the Archdiocese of New Orleans, chaperones, or representatives associated with the activity that said person becomes ill with symptoms such as headache, vomiting, sore throat, fever, diarrhea, I want to be called collect (with phone charges reversed to myself).

Signature: _____ Date: _____

<u>SECTION IV:</u> **<u>MEDICATIONS</u>** *(Sign only those options that are applicable))*

- Said person is taking medication at present. Said person will bring all such medications necessary, and such medications will be well-labeled. Names of medications and concise directions for seeing that the said person takes such medications, including dosage and frequency of dosage, are as follows: _____
  Signature: _____Date: _____
- I hereby grant permission for non-prescription medication (such as aspirin, throat lozenges, cough syrup) to be given to said person, if deemed appropriate.
  Signature: _____Date: _____
- NO medication of any type, whether prescription or non-prescription, may be administered to said person unless the situation is life-threatening and emergency treatment is required.
  Signature: _____Date: _____

<u>SECTION V:</u> **<u>MEDICAL INFORMATION</u>**

The parish 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 said person have a medically prescribed diet? __

_____ Any physical limitations? _____

_____

Is said person subject to chronic homesickness, emotional reactions to new situations, sleepwalking, bed-wetting, fainting? _____

Has said person 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 said person:_____

_____