UNSTOPPABLE

FALL RETREAT 2009 LIABILITY WAIVER/RELEASE FORM

Participant's Name _____ Date of Birth _____

Address _____Telephone _____

City _____State _____ Zip Code _____

Email _____ T-shirt Size _____

I, _____ (Parent/Guardian), give permission to my son/daughter to attend the fall retreat on November 6-8th, 2009 at the Catholic Camps of America in Dutzow, MO. If needed for medical reason, I give permission for my child to be evaluated, diagnosed, treated, and/or given medication in accordance with standard medical practice by health care personnel. I release the Catholic Camps of America, St. Catherine Laboure and other participating parishes, the chaperones, its staff, its agents and the Archdiocese of all responsibility and consequences that may arise as a result of any injury suffered and/or resulting treatment. Further, I agree to accept any and all financial responsibility as a result of such medical treatment.

My child agrees to abide by all the rules and regulations of the camp and St. Catherine Laboure Youth Ministry. I understand that the Catholic Camps of America, St. Catherine Laboure, its chaperones, staff, agents or the Archdiocese will not be liable if my child fails to cooperate with regulations, and that infractions of the rules may result in immediate dismissal from the retreat at my expense.

I understand that if my youth behaves in a manner that is deemed inappropriate or is continually disruptive or if my youth is found with illegal drugs or alcohol (zero tolerance policy), I will be called to immediately pick up my youth from the retreat site.

_____ _____

Signature of Parent/Legal Guardian Date

Family Doctor _____Phone _____

Health Insurance Company_____Policy #_____

Allergies _____Medications_____

Medical History _____

Family Dentist_____Phone_____

IN CASE OF AN EMERGENCY, PLEASE CONTACT:

1. Name _____ Home/Cell Phone _____
Address_____

2. Name _____ Home/Cell Phone_____
Address_____

ONE FORM MUST BE COMPLETED FOR EVERY PERSON ATTENDING.