Office of Faith Formation and Lay Ecclesial Ministry
Office of Youth and Young Adult Ministry

YOUTH Combined Registration, Medical Release/Permission Form

(Youth Ministry Summer Fishing Retreat)

(Please print or type all information, except signatures, and complete both sides of this form.)

I. First Name: _____ Middle Initial: _____ Last Name: _____

Address: _____

City, State, Zip: _____ Phone: _____

Email address: _____

Parish/School/Organization (group you are registered with):_____

Mother/Guardian: _____ Father/Guardian: _____

Additional Emergency Phone Numbers (please identify as work, cell, etc.)_____

Date of birth: _____ Male ___ Female ___ Grade: 9 10 11 12

Circle ANY that apply: Wheelchair Access/Mobility Impaired Blind/Visually Impaired

Hearing Impaired Interpretation Needed Interpretation Not Needed

Please note: All areas utilized are not ADA accessible.

Contact (St Teresa of Calcutta Parish 330372-2215) if special arrangements need to be made.

II. Youth Agreement

I understand that my participation in this program requires compliance with specific regulations for this event. I agree to abide by all rules and regulations set forth. Any infraction of the rules or regulations, including, but not limited to, the possession of alcohol, drugs, or weapons will result in dismissal from the program. If I should be dismissed, I understand that my parents will be contacted to arrange for my immediate transportation home.

Youth Signature: _____ **Date:** _____

III. Parental Agreement

I, the parent/guardian of _____ who is less than nineteen years of age, grant permission for my daughter/son to participate in the (fishing retreat) at (Thirion Family Campground 1966 Cream Ridge Rd, Orwell OH) on (Friday August 2, 2024) (St Teresa of Calcutta Parish) _____. By allowing my child to participate in the said program, I hereby assume all risk of accident or harm arising or growing out of, directly or indirectly, any incident of any kind occurring during the course of such program to my child and do hereby release and discharge the Bishop of the Diocese of Youngstown, and St Teresa of Calcutta Parish parish/school/organization, and the agents, associates, and employees of the Bishop and parish/school who have organized or participated in the supervision of such program from all claims, demands, suits, causes or actions, rights, costs, expenses, and any compensations whatsoever which may occur to my family and its members during or resulting from participating in the program mentioned.

Signature: _____ **Date:** _____

I am aware of the particulars of the said program including the times, costs, and adults chaperoning and transporting my child for the program and have clarified any concerns I may have with the coordinating adult in charge. I agree that my son/daughter shall abide by the rules and all regulations of the program including in possession of alcoholic beverages drugs, and weapons. I agree that if my son/daughter fails to abide by the regulations set forth, he/she will be dismissed from the program and I will need to arrange for his/her immediate transportation home at my expense.

Signature: _____ **Date:** _____

I understand that photographs or video taken at this event may be used in parish or diocesan publications.

Signature: _____ **Date:** _____

I hereby authorize the parish/group to communicate directly with my child, or indirectly through me, via:
□ Cell phone text message; cell number(s)_____
□ Facebook (or other Social networking); under the name(s) of: _____
□ Email; at this address(es) _____

IV. Medical Information

(Please check and sign only those below which are in accordance with your wishes; do not sign all sections.)

Select this:

□ In the event of an emergency, I hereby grant permission to transport my son/daughter and obtain emergency medical or surgical treatment from a licensed physician, hospital, or medical clinic. I hereby authorize medical personnel to release necessary information about his/her care to the parish or school group leaders(s) named here _____. I wish to be advised prior to further treatment by the hospital or doctor. In the event I cannot be reached, please contact _____ at _____. Relationship to youth _____. Family physician _____ Phone _____.

(Please check one of the following)

□ My son/daughter is covered by hospitalization and medical insurance under policy#_____issued by_____.
□ My son/daughter does not have medical coverage and I assume responsibility for the cost of hospitalization and medical care for my son/daughter.

Signature: _____ **Date:** _____ ***Or this:***

□ I hereby warrant that to the best of my knowledge, my son/daughter is in good health. **I do not want any medical treatment to be given to my son/daughter under any circumstances.** I hereby assume all responsibility for the health and well being of my son/daughter and release from responsibility the Bishop of the Diocese of Youngstown, and _____ parish/school, and the agents, associates, and employees of the Bishop and parish who have organized or participated in the supervision of such program.

Signature: _____ **Date:** _____

Select this:

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

Signature: _____ **Date:** _____ ***Or this:***

□ I hereby grant permission for nonprescription medication (such as acetaminophen, decongestant, cough syrup) to be given to my son/daughter, if requested by my son/daughter and deemed advisable by an adult chaperone.

Signature: _____ **Date:** _____

□ My son/daughter is taking medications at present. He/she will bring all necessary medications and such medications will be well labeled. The names of and the concise directions for taking such medications, including dosage and frequency of dosage as follows: _____

Signature: _____ **Date:** _____

□ I wish to inform you of the following additional medical information and the recommended course of action (allergies, dietary restrictions, special conditions, etc.)_____

Signature: _____ **Date:** _____

□ I would like to have a member of the program staff speak with me further regarding a medical concern or situation. Please contact me at _____.

Return completed form to: _____ **by:** _____