

**St. Colette FOCUS YM, St. John the Evangelist -CRUSH YM, Our Lady of Wayside, and Queen of Rosary
KAIROS Retreat #6 – February 16th thru 19th, 2018
Bishop Lane Retreat Center, 7708 E. McGregor Rd., Rockford, Illinois 61102
Youth Permission & Parental/Guardian Authorization**

I hereby give permission for my son/daughter _____ (name) to participate in the Kairos Retreat held at the Bishop Lane Retreat Center. **I understand that transportation for this event will be via Bus from St. Colette Parish/St. John Evangelist Parish to the Bishop Lane Retreat Center in Rockford, Illinois.** I also understand that my child will be under supervision and that all adult leaders from the Parish/School/Deanery/Vicariate will be in compliance with the guidelines from the Archdiocese of Chicago in regards to the Virtus Training and Protecting God's Children requirements.

I HEREBY RELEASE AND INDEMNIFY THE CATHOLIC BISHOP OF CHICAGO, A CORPORATION SOLE, St. Colette Catholic Church, St. John the Evangelist Parish-CRUSH, Our Lady of Wayside, and Queen of Rosary, it's staff and volunteers from any and all liability arising from claims of any kind or nature whatsoever from my teen's participation in this event.

I UNDERSTAND that if my son/daughter violates any laws regarding possession of alcohol or drugs, or rules governing the event, arrangements will be made to immediately send my teen home at the cost of the parents/guardian.

IN THE EVENT THAT THE UNDERSIGNED CANNOT BE REACHED AND IN THE JUDGEMENT OF THE RESPONSIBLE ADULT AT THIS EVENT or other staff member, there is a necessity for immediate examination and/or treatment of my teen, I HEREBY AUTHORIZE ANY OF THE AFORESAID PERSONNEL TO OBTAIN FOR MY TEEN, SUCH MEDICAL SERVICES AS ARE DEEMED NECESSARY.

*****I GRANT PERMISSION for the adult chaperones for this event to administer non-prescription drugs as needed for my teen i.e., aspirin, ibuprofen, antacids, etc.)**

YES _____ NO _____

*****I AUTHORIZE St. Colette Catholic Parish, St. John the Evangelist Catholic Parish, FOCUS or CRUSH Youth Ministry, and The Archdiocese of Chicago to use photographs/videos of my teen for productions, publications, website and facebook.**

YES _____ NO _____

PARENT/GUARDIAN

SIGNATURE: _____ **DATE:** _____

TELEPHONE # (h) _____ **(cell #)** _____

EMERGENCY CONTACT: _____ **PHONE** _____

RELATIONSHIP _____

(Over)

*****PLEASE LIST ANY ALLERGIES, MEDICATIONS, MEDICAL PROBLEMS, PHYSICAL ACTIVITIES/LIMITATIONS that your teen CANNOT take part in AND/OR any other important information.**

CURRENT MEDICATION: _____

PHYSICIAN INFORMATION:

Name of Physician _____ **Phone:** _____

Address: _____ **City** _____ **State:** _____ **Zip:** _____

INSURANCE INFORMATION:

Policy in the name of: _____

Insurance Company: _____

Policy number: _____

Identification number: _____