PARENTAL RETREAT NOTIFICATION,
LIABILITY WAIVER, AND MEDICAL INFORMATION FORM.

We, the parent or guardian of _____
(Child's name)

permit our daughter to attend the Daughters of the Immaculata 2019 Winter Retreat, occurring within the St. Alphonsus Ligurori parish campus areas.
(name of trip/destination)

being planned by Laurel Tobin on Thursday, January 3 – Friday, January 4, 2018.
(parish representative) (date)

from **8:30 a.m. on Thursday** to **noon on Friday**. The purpose of this retreat is: to begin the new calendar year with an opportunity to reflect upon and renew our Catholic faith as maturing Catholic women.

I, as parent/guardian of the undersigned minor, hereby consent and agree to hold harmless, St. Alphonsus Liguori Parish and/or the Roman Catholic Diocese of Lafayette-in-Indiana, Inc., and any and all employees or volunteers thereof, for any accident, injury or occurrence arising out of, or in connection with the activity of my child while present at this retreat.

I give my permission for my daughter, in case of an emergency, to be taken to a physician or hospital by either a chaperone in charge or by parish personnel. I understand that every effort will be made to contact me. If I cannot be reached, I hereby give permission to the physician selected by the parish member in charge or adult chaperone(s) to secure proper treatment for my daughter.

Child Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Accident/Hospitalization Policy Name: _____

Policy Number: _____

PLEASE NOTE THAT A PARENT /GUARDIAN MUST COMPLETE, SIGN AND DATE THIS AND THE MEDICAL INFORMATION ON THE OTHER SIDE FOR EACH CHILD IN ATTENDENCE.

**** Please add any special dietary needs:**

MEDICAL MATTERS: I hereby warrant that to the best of my knowledge, my child is in good health, and I assume all responsibilities for the health of my child. Of the following statements pertaining to medical matters, **sign only those in accordance with your wishes.**

Emergency Medical Treatment: In the event of an emergency, I hereby give permission to Parish, it's officers, directors and agents, and Diocese of Lafayette-in-Indiana, agents, representatives, volunteers and employees of either the diocese or any parish thereof, and chaperones or representatives associated with this event 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 above numbers, contact:

NAME and RELATIONSHIP: _____
Telephone: ( )_____
FAMILY DOCTOR: _____
Telephone: ( )_____
FAMILY HEALTH PLAN CARRIER_____
Policy Number: _____

(1) Signature: Date:

Other Medical Treatment: In the event it comes to the attention of the parish, its officers, directors and agents, and the Diocese of Lafayette-in-Indiana and all parishes within the diocese, and the officers, agents representatives, volunteers and employees of either the diocese or any parish thereof, and chaperones or representatives associated with the event, that my child becomes ill with symptoms such as headache, vomiting, sore throat, fever, diarrhea, I want to be called collect (with telephone charges reversed to myself**).**

(2) 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 as follows:

(3) 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.

(4) Signature: Date:

I hereby grant permission for non-prescription medication (such as aspirin, throat lozenges, cough syrup) to be given to my child, if deemed advisable.

(5) Signature: Date:

Specific Medical Information: Parish will take the 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:

Medications child currently takes:

Does child have a medically prescribed diet?

Any physical limitations?

Is child subject to chronic homesickness, emotional reactions to new situations, sleepwalking, bedwetting, fainting?

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

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