

# CONFIRMATION RETREAT

## Confirmation Class of 2025

**Participant's Full Name** \_\_\_\_\_

Date of Birth \_\_\_\_\_ Gender \_\_\_\_\_ Grade \_\_\_\_\_

Address \_\_\_\_\_ Zip \_\_\_\_\_

Parent(s)' Name(s) \_\_\_\_\_

Home Number \_\_\_\_\_ Daytime # of parent \_\_\_\_\_ Cell Phone \_\_\_\_\_

E-mail to receive information, updates about this event: \_\_\_\_\_

Emergency Contact  
(Other than Parent) \_\_\_\_\_ Phone \_\_\_\_\_

Any allergies or medical, physical, or dietary restrictions/requirements:

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Medications presently taking (including over-the-counter medications):

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Medical Insurance Company \_\_\_\_\_

Policy ID Number \_\_\_\_\_

**COMPLETE BOTH SIDES**

If your child may participate in this event, please complete, sign and return the following statement of consent and release of liability. As parent/guardian, you remain fully responsible for any liability which may result from personal actions taken by your son/daughter. **If your youth brings or uses any drugs, alcohol, weapons, or tobacco products or engages in reckless or violent behavior, you will be expected to retrieve your son/daughter from the trip.**

I hereby consent to the participation of my child, \_\_\_\_\_, in the event described above. I further consent to the conditions stated above regarding participation in this event.

I release the Diocese of Raleigh, St. Andrew and their agents and volunteers from any injuries which may be incurred by my youth.

I give permission for my child, in case of emergency, to be taken to a physician or hospital by either an adult youth leader, diocesan or parish personnel. I understand that every effort will be made to contact me. *If I cannot be reached*, however, I hereby give permission to the physician selected by the adult in charge, to hospitalize and secure proper treatment, including surgery, for my son/daughter.

I hereby grant permission to any staff person to provide the following **over-the-counter drugs** to my son/daughter if requested by my son/daughter (please check all that apply). Note: category of medicine and an example are listed, although a different brand may be used. Doses are not to exceed manufacturer's recommended dosages.

<input type="checkbox"/> Ibuprofen (Advil)	<input type="checkbox"/> Acetaminophen (Tylenol)
<input type="checkbox"/> Antibiotic Ointment (Neosporin)	<input type="checkbox"/> Antihistamine/Decongestant
<input type="checkbox"/> Antacids (Rolaids, Tums)	(Actifed/Sudafed/Benadryl)

Parents/guardians of participants are advised that **photographs or videotape** of participants may be used in publications, websites or other materials produced from time to time by the Youth Ministry Office or the Diocese of Raleigh. Participants would not be identified unless there is specific written consent. Parents/guardians who do not wish their children to be photographed or filmed should so notify the Youth Ministry Office in writing.

I have read and understand the information in this permission form.

Parent/Guardian  
Signature \_\_\_\_\_

Date \_\_\_\_\_