

RESURRECTION YOUTH MINISTRY

Email dhallock@resurrectionparishnj.org 973-895-4224 ext. 107

SEEK Retreat Application

2016-2017

Please return this application by November 10 for December Retreat or April 13 for May Retreat (we take candidates on a first come first serve basis). Please make checks payable for **\$120.00 to Resurrection Youth Ministry:**

Dolores Hallock
Resurrection Youth Ministry
651 Millbrook Ave.
Randolph, NJ 07869

[Please print]

Candidate's Name: _____ Male ____ Female ____

Address: _____

City: _____ Zip Code: _____

Parent's Primary Phone: _____ Parent's Email: _____

School: _____ Grade: _____

PARENTS:

I give permission for my son/daughter

_____ to participate in the SEEK overnight retreat to be held at:

_____ Retreat Center, (St. Mary's Abbey) - Delbarton, Morristown, NJ on December 2-3, 2016

_____ Retreat Center, (St. Mary's Abbey) - Delbarton, Morristown, NJ on April 28-29, 2017

Parent's Signature: _____

PLEASE NOTE

Bring: Casual and warm (winter retreat) clothing
Toilet articles

NO SLEEPING BAG OR TOWELS ARE NECESSARY

Transportation: Carpool to St. Mary's Abbey - Delbarton

Cost: **\$120.00**

[Over]

HEALTH INFORMATION/RELEASE OF LIABILITY/CONSENT TO TREAT:

I, _____
(Parent's name)

Of _____, _____
(City) (State)

Do hereby state that I am the parent/guardian having legal custody of _____
(Child's name)
a minor, age _____.
(Age)

I authorize _____, an adult who is
(Leave blank)

Chaperoning the
() Seek Retreat – December 2-3, 2016 in Morristown, NJ
() Seek Retreat – April 28-29, 2017 in Morristown, NJ

to consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment, and hospital care to be rendered to the minor, at a recognized medical facility, under the general or special supervision of a licensed physician or surgeon.

RELEASE OF LIABILITY: In consideration of Resurrection Parish accepting my teens registration for this event (and in consideration of Dolores Hallock accepting my registration), I release, hold harmless and discharge Resurrection Parish, its officers, Trustees, employees, agents and chaperone affiliates, of and from any and all liability, claim, loss, damage, cost or expense and waive any such claims against any such person or organization arising directly from or attributable to any action or omission to act of any such person or organization in connection with this event.

*** _____ *** Date: _____
(Signature of Parent or Guardian)

Is the child undergoing counseling? _____ yes _____ no

Counselor's name: _____ Telephone #: _____

Existing medical problems of child, if any _____

Child's allergies, if any _____

Child's Doctor: _____ Dr.'s Telephone #: _____

Choice of Specialist: _____

Medicine child is taking: _____

Insurance Company: _____, Group #: _____

Identification #: _____ Date of last tetanus shot: _____

Cell or Telephone number where parent or guardian can be reached during this event:
