RESURRECTION YOUTH MINISTRY

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

SEEK Retreat Application

2017-2018

Please return this application by <u>November 27 for December Retreat or April 30 for May Retreat</u> (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: ______________

Cell or Primary Phone: ____

Parent's Email for information regarding the retreat: ______________________________________

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 1-2, 2017

____Retreat Center, (St. Mary's Abbey) - Delbarton, Morristown, NJ on May 4-5, 2018

Parent's Signature: ____

<u>PLEASE NOTE</u>

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 1-2, 2017 in Morristown, NJ
( ) Seek Retreat – May 4-5, 2018 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 (if different than above)