

RESURRECTION YOUTH MINISTRY

Email dhallock@resurrectionparishnj.org 895-3989

SEEK Retreat Application

2011-2012

Please return this application by November 1 for December Retreat or March 1 for April Retreat (we take candidates on a first come first serve basis). Please make checks payable for \$115.00 to Resurrection Youth Ministry:

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

[Please print]

Name: _____ Male _____ Female _____

Address: _____

City: _____ Zip Code: _____

Phone: _____ Cell _____ Parish: _____

School: _____ Grade: _____

PARENTS:

I give permission for my son/daughter _____
to participate in the SEEK overnight retreat to be held at:

_____ St. Mary's Abbey - Delbarton, Morristown, NJ on December 09-10, 2011

_____ St. Mary's Abbey - Delbarton, Morristown, NJ on April 27-28, 2012

Parent's Signature: _____

PLEASE NOTE

Bring: Casual and warm clothing
Toilet articles
Pillow for sitting on floor
NO SLEEPING BAG IS NECESSARY

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

Phone for weekend only: Dolores Hallock Cell (973) 906-1596

Cost: \$115.00

[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 9-10, 2011 in Morristown, NJ
- () Seek Retreat – April 27-28, 2012 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:

_____.