

Type of event: **Mary Queen Youth Fall Retreat** Date of event: **Oct. 21-23**
Location: **Aldersgate Camp Retreat Center, Ravenna, KY phone: 606-723-7848**
125 Aldersgate Camp Road 40472

Individual in Charge: **Angie Allen**

Student's Name: (Print, please) _____

Does the student have any allergies? _____

Birthdate: _____ Home Phone No.: _____ Emergency Phone _____

Parent / Guardian's Name: (Print, please) _____

Address of Parent / Guardian: (Print, please) _____

As parent and/or legal guardian, I remain legally responsible for any personal actions taken by the above named minor ("participant"). I agree on behalf of myself, my child named herein, or our heirs, successors, and assigns, to hold harmless and defend Mary Queen of the Holy Rosary Church, its officers, directors, employees and agents, and the Diocese of Lexington, its employees and agents, chaperones, or representatives associated with the event, from any claim arising from or in connection with my child attending the event or in connection with any illness or injury (including death) or cost of medical treatment in connection therewith, and I agree to compensate the parish, its officers, directors and agents, and the Diocese of Lexington, its employees and agents and chaperones, or representative associated with the event for reasonable attorney's fees and expenses which may incur in any action brought against them as a result of such injury or damage, unless such claim arises from the negligence of the parish/diocese. Furthermore, I hereby warrant that to the best of my knowledge, my child is in good health, and I assume all responsibility for the health of my child. In the event of an emergency, I hereby give permission 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, the following person may be contacted:

PRINTED NAME OF EMERGENCY CONTACT PHONE NUMBER

Student's Family Doctor: _____ Phone Number: _____

Family Health Plan Carrier: _____ Group/Policy Number: _____

Signature of Student's Parent/Guardian: _____ Today's Date: _____

Any special considerations, concerns: _____

