INITIUM NOVUM

High School Senior Retreat 2018
O'Reilly Catholic Student Center
Date: **April 20-21st.**
Cost is $25
Make checks out to Catholic Campus Ministry
Application must be turned in by April 14th.

Name: _____ Gender: _____

E-mail: _____ High School: _____

Phone: _____ Birthday: _____

Address: _____

_____

_____

Please tell us a little about yourself. _____

_____

_____

University you plan attending in Fall 2018 _____

EMERGENCY CONTACT INFORMATION
(Parent/Guardian)

In the event of an emergency, I/we hereby give permission to transport my/our child to a hospital for treatment by the hospital or doctor. I wish to be advised prior to any further treatment by the hospital or doctor. In the event of an emergency reach me/us at the contact information below:

Parent/Guardian Initial here to indicate consent: _____

Emergency Contact Name:_____

Relationship to student:_____

Cell Phone:_____ other phone:_____

Family Doctor:_____

Phone #:_____

Family Health Plan Carrier: Policy #:_____

PARENT/GUARDIAN CONSENT FORM LIABILITTY WAIVER

Participant's Name: _____

I/we, (names of parents or guardian) _____, grant permission for my/our child whose name is listed above, to participate in the High School Senior Retreat at the O'Reilly Catholic Student Center on April 20-2st. This activity will take place under the guidance and direction of diocesan employees and/or volunteers. As parent(s)/guardian, I/ we remain legally responsible for any personal actions taken by the above named minor (participant).

I/we agree, on behalf of myself, my child named herein, or our heirs, successors, and assigns, to hold harmless and defend the O'Reilly Catholic Student Center and the Diocese of Springfield-Cape Girardeau, their officers, directors, employees and agents, chaperones or representatives associated with the event, from any claim arising from or in connection with my/our 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 catholic student center and diocese, their officers, directors, employees, agents and chaperones or representatives associated with the event for reasonable attorney's fees and expenses which they 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 catholic student center or diocese.

I/we hereby warrant that to the best of my/our knowledge, my/our child is in good health, and I/we assume all responsibility for the health of my/our child.

I/we hereby release to the O'Reilly Catholic Student Center and diocese of Springfield-Cape Girardeau the rights of my child's photographs/ audio/videos, for the purpose of promotion, video, web site or publications of the diocese.

THE DIOCESE RECOMMENDS THAT STAFF, VOLUNTEERS, AND PARENTS NOT POST TO SOCIAL MEDIA OR DISTRIBUTE PERSONAL IDENTIFIABLE INFORMATION, INCLUDING PICTURES OF ANY CHILD UNDER THE AGE OF 18, WITHOUT VERIFIABLE CONSENT OF PARENT OR GUARDIAN.

Parent/Guardian Signature: _____Date:_____

This form may not be signed electronically. Please print, sign, submit, or mail to

Catholic Campus Ministry
847 S. Holland Ave
Springfield, Mo, 65806

jvelten@scspk12.org

MEDICAL HISTORY

(The Catholic Student Center will take responsible care to see that the following information will be held in confidence)

Date of last Tetanus (DPT) Immunization (REQUIRED):_____

Allergic reactions (medicines, food, plants, insects, etc):_____

Does your child have a medically prescribed diet?_____

If your child has a food allergy or specific dietary need, please clearly detail foods that your child definitely must avoid and suggestions for some foods they will eat within their dietary needs. If you would like to discuss specific food needs, please call _____so we can accommodate your child, if possible.

Any physical limitations, phobias, sleep walking, etc.?_____

Has your child been recently exposed to any contagious diseases or condition? If yes, date and describe condition._____

_____

You should be aware of these special needs or medical conditions of my/our child:

_____

_____

_____

MEDICATION

Of the following statements pertaining to medical matters, Parent/Guardian please initial ONLY those that are applicable

_____ In the event it comes to the attention of the diocese, its officers, directors, chaperones or representatives associated with the activity that my/our child becomes ill with symptoms such as headache, vomiting, sore throat, fever, diarrhea, I/we want to be called.

_____ No Medication of any type, whether prescription or non-prescription, may be administered to my/ our child unless the situation is life-threatening and emergency treatment is required.

_____ I/we hereby grant permission for non-prescription medication (such as Tylenol, throat lozenges, cough syrup) to be given to my/our child, if deemed advisable.

_____ My/our child is taking medication at present: (List all medications your child will bring to the retreat, the condition for which they are prescribed, and the directions for their use.)

Medications	Conditions	Directions for use

Over the Counter Medications (Tylenol, Advil, Aspirin, Antibiotic Ointments, Anti-Itch Ointments, Cold Medicine, etc.) must be turned into the nurse at check-in.

If a child needs to carry an asthma inhaler or epi pen with them at all times, we need a signed note from the physician stating that this medication is needed and that the child has been instructed in the correct self-administration of those medications.

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