FLAME 2 Retreat 2020

PERMISSION & AUTHORIZATION FORM FOR MEDICAL TREATMENT

I/We, the parent(s) of______________________________________request that Holy Family Teen Faith program allow my/our child to participate in

Event: FLAME 2 Retreat
When: January 25-26, 2020
Place: Holy Family Parish, Inverness, IL

I hereby release and indemnify Holy Family Parish, its staff and its volunteers and the Catholic Bishop of Chicago, a corporation sole, from any and all liability arising from claims of any kind or nature whatsoever from my child's participation in this event.

In the event that the undersigned or my (our) authorized physician, cannot be reached, and in the judgment of a responsible person accompanying the group, or other appropriate staff member, there is a necessity for immediate examination and/or treatment of my (our) child, I/We hereby authorize any of the aforesaid people to obtain for my child such medical services as are deemed necessary.

Home Phone Number ____________________ Other number (if applicable) ____________________

Family Physician _________________________ Phone Number ______________________________

Name of Insurance Co. _____________________ Policy Number ______________________________

Person to contact in case of emergency (if unable to reach parent):

______________________________ ____
Name/Relationship Phone Number

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Parent(s) Name(s)

Specific medical allergies, food allergies, chronic illnesses and other conditions. Please list any & all medications that your child may take during the retreat.
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____ __________________________
Parent/Guardian Signature **Date**