# IGNITE 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: IGNITE G.L.O.W. RETREAT – "Ignite Your Light, Becoming Yourself."**

**When: 3:45pm Saturday, February 1st 2020 – 10am Sunday (after the 9am Mass), February 2nd 2020**
*This is an "**overnight-encouraged**" retreat. If your child will not spend the night, their pick-up will be at **11pm Saturday**. Also, if they don't stay the night, we'd ask your family to still come the next day for the 9am Mass!

Will your child stay the night? Please check your answer! **Yes___ No___**

**Place: Holy Family Catholic Community in 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: _____

_____
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.
_____
_____

_____ _____
**Parent/Guardian Signature** **Date**

_____
**Parent Initials**