St. John Paul II Adventure Day

Date: Fri-Sat, April 20 - 21 **Begins**: 4pm Friday **Ends**: 8:30pm Saturday
Location: Clemente's home/grounds 150 Rustic Ridge Rd
Fredericksburg, VA 22405
Cost: $25, snack to share & a permission slip **RSVP**: March 30
Bring: Sleeping bag, pillow, toiletries, tent *(if you have one),* sweatpants/sweatshirt for sleeping, change of clothes *(suitable for lots of outdoor activities),* jacket, hat, flashlight.

*****Parents!*** We are in need of folks to help cook dinner *(Friday night)* and bfast *(Saturday morning).* We will also need help w/general chaperoning. Let us know if you can help.

Detach and retain this section for your information.

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Detach and return this section with payment by Friday, March 30th.

St. John Paul II Adventure Day Permission Slip

Parental Permission & Liability Release: As the parent/guardian of ____________________________, I hereby give my permission for my child named above to participate fully in the St. John Paul II Adventure Day held at the Clemente home from Friday, April 20 until Saturday, April 21. I agree to indemnify and hereby release The Most Reverend Michael Burbidge Bishop of the Catholic Diocese of Arlington and his successors in office, as well as the Catholic Diocese of Arlington and all Diocesan clergy, employees, volunteers, and participating parishes and schools from any and all liability, claims, demands for personal injury, sickness and death, as well as property damage and expenses of any nature whatsoever which may be incurred by the undersigned of the participant resulting from said participant's involvement in the above mentioned event (including transportation to and from the event). Furthermore, I on behalf of the participant hereby assume all risk of personal injury, sickness, death, damage, and expenses resulting from said participant's involvement in the above described event.

Informed Consent to Medical Treatment: I request that in my absence the above-named minor be admitted to any hospital or medical facility for diagnosis and treatment. I request and authorize physicians, dentists, and staff, duly licensed as Doctors of Medicine or Doctors of Dentistry or other such licensed technicians or nurses, to perform any diagnostic procedures, treatment procedures, operative procedures and x-ray treatment of the above minor. I have not been given a guarantee as to the results of examination or treatment. I authorize the hospital or medical facility to dispose of any specimen or tissue taken from the above-named minor. I assume full responsibility for all costs of such treatment. Further, should it be necessary for the participant to return home due to medical, disciplinary, or other reasons, I do hereby assume responsibility for the participant's transportation home and any costs related thereto.

Photo: Also, I authorize the Diocese of Arlington to use my child's picture or video recording for educational and/or marketing purposes. Parents/guardians who do not wish their child to be photographed or filmed should notify the Office of Youth Ministry in writing.

Date of Birth	Grade	If a Vegetarian please specify here
Allergies or medical conditions/concerns *(Continue on back of form if needed)*		
Name of Parent/Guardian	E-mail of Parent/Guardian	
Address		City/State/Zip
Phone: Home	Work	Mobile
Person to notify if parent/guardian is unavailable		
Phone: Home	Work	Mobile
Insurance Carrier & Policy Number	Family Physician Phone	
Signature of Parent/Guardian	Date	