Confirmation Retreat Details

Meet at: 8:15AM **Pick up**: 3:30PM **Cost**: $40 fee & permission slip **RSVP:** October 15th

Location: Holy Cross Academy, 250 Stafford Lakes Parkway Fredericksburg, VA 22406.
Retreat Assignments: N*ovember 3 (Teams 1-11) | November 10th (Teams 12-22).*

Details: Lunch will be provided. Dress code is casual but appropriate.

LEAVE AT HOME: iPods, cell phones, homework & school books, etc.

Detach and retain this section for your information.

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Detach and return this section with payment by the RSVP October 15

Team #_____

Confirmation Retreat Permission Slip

Parental Permission & Liability Release: As the parent/guardian of _____, I hereby give my permission to participate fully in the Confirmation Retreat on Saturday, November 3 or November 11th from 8:15am to 3:30pm at Holy Cross Academy. 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	