High School Lock-In Details

Date: Fri-Sat, Nov. 30 – Dec. 1 **Begins**: 9:00 pm Friday **Ends**: 7:00 am Saturday
Cost: $10 & drink to share **Location**: Holy Cross Academy **RSVP by**: Nov. 19th

Parents: We would love help chaperoning for our 4, 3 hour shifts throughout the night, putting out snacks, etc. Please contact Tatiana if you are interested and able to help out in any way at tbeltran@stmaryfred.org or 373-6491.

~PLEASE DO NOT ARRIVE BEFORE 9:00 PM~

To Bring: Sleeping bag, pillow (if you want to sleep), toiletries, clothes to sleep in, games, movies (No R-rated)

Detach and retain this section for your information.

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Detach and return this section with payment by the RSVP deadline of Monday, Nov. 19th

High School Lock-In Permission Slip

Parental Permission & Liability Release: As the parent/guardian of ____________________________, I hereby give my permission to participate fully in the High School Lock-In, at Holy Cross Academy from Friday, November 30 until Saturday, December 1st. 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