

St. Michael's 10th Grade Retreat April 11-12, 2026

I hereby permit _____ (Child's Name)
to participate on :April 11 &12th to Creighton Retreat Center in Griswold.
Parish & School my child attends: _____ Current Grade level: _____
Student email: _____ Student Cell # _____

Read and Initial;

- I agree to direct my child to cooperate and conform to directions and instructions of the supervisory personnel in charge of this event.
- Should it be necessary for my child to have medical treatment while participating in this event, I hereby give the personnel permission to use their judgment in obtaining medical service for my child, and I give permission to the physician selected by the personnel to render medical treatment deemed necessary and appropriate by the physician.
- I understand any insurance benefits that are effective have limited application.
- I understand if my child is found to have alcohol, any illegal controlled substance or tobacco in their possession, the personnel in charge will take appropriate action. Inappropriate behavior will also be dealt with up to and including calling me for immediate retrieval of my child.
- I give permission for my child to participate in all the activities associated with this event. I also give permission for my child to be transported to and from this event's destinations. I assume responsibility for my child's transportation to and from drop-off/pick-up site.
- Photo Release: I grant permission for my child's photo to be used without compensation in promotional material for the youth group such as but not limited to bulletins, newsletters and the church website.

Parent/Guardian Signature Date

Address Phone Number Mom Cell

City and Zip Phone Number Dad Cell

Parent email: _____

Please Complete Medical Information on back side of this form

Specific Medical Information for: (Student) _____

*The information requested is necessary to permit treatment at a medical facility. Reasonable care will be taken to keep the information confidential.

If parents cannot be reached, please call: Name: _____
Phone _____ Relationship to student: _____

INSURANCE INFORMATION ABOUT POLICY HOLDER :

- Name of Policy Holder: _____
- Policy Holder's Date of Birth: _____
- Insurance Company Name: _____
- Insurance Company Phone #: _____

HEALTH/MEDICAL INFORMATION ABOUT STUDENT:

- Participant's Date of Birth: _____
- Policy Number _____
- Allergic reactions (medications, food, plants, insects, etc.): _____
- Immunizations: Date of last tetanus/diphtheria: _____
- Medically prescribed dietary needs: _____
- Any physical limitations: _____
- Does your child use any of the following devices: Contact lens, hearing aid, glasses or asthma inhaler? _____
- Other: _____
- Additional special medical conditions staff should be aware of: _____

MEDICATIONS: My child is taking medication at present. YES/NO

If yes, my child will bring such medications necessary in original container and well labeled.

Names of medications and concise directions must be on the label. All participants will be responsible for taking their own medications for the duration of this event.

My child is currently taking these medications (please indicate dosage and frequency):

Signature: _____ Date: _____
(Parent or Guardian)

I hereby grant permission for nonprescription medication (such as aspirin, non-aspirin, lozenges or cough syrup) to be given to my child, if deemed advisable. Yes _____ No _____

Signature: _____ Date: _____
(Parent or Guardian)

BOTH SIDES MUST BE FILLED OUT