9th/10th Grade Confirmation Retreat
GENERAL PERMISSION SLIP

ARCHDIOCESE of MILWAUKEE

Form 6153(b)

STUDENT NAME AND GRADE in Fall 2026	STUDENT BIRTHDATE CIRCLE: Male Female
NAME OF PARENT/GUARDIAN	NAME OF PARENT/GUARDIAN PHONE:
FAMILY PRIMARY ADDRESS	PRIMARY EMAIL ADDRESS

TRIP INFORMATION TO BE FILLED IN BY OFFICE PRIOR TO EVENT

PARISH/SCHOOL: St. Mary Catholic Church	EVENT DATE(S): 02/06/2027
DESIGNATED TEACHER/SUPERVISOR: Wyatt Cupp 11th Grade Catechists | Spiritus Ministries Missionaries	PHONE: (262) 925-4157 | Wyatt Cupp
DESTINATION St. Mary Catholic Church Campus | Kenosha	
ACTIVITIES: (A SEPARATE DETAILED ITINERARY AND PARENT CONSENT MUST BE PROVIDED FOR HIGH RISK ACTIVITIES.) Confirmation Retreat	
MODE OF TRANSPORTATION TO AND FROM EVENT: By Family	
DAILY START TIME: Retreat BEGINS AT 9:00am – will be attending 4:00pm Mass | Lunch will be served with snacks throughout the day.	DAILY END TIME: 5:00pm
STUDENT COST (IF APPLICABLE): $30	RETURN FORM BY: **Sunday, January 3, 2027**
ITEMS STUDENTS SHOULD BRING (IF ANY): n/a – just a willingness to be open to the Holy Spirit working within! Cell Phones will be collected prior to the start of retreat.	

Parent Consent to Participate and Indemnity Agreement

In consideration for my child/ward's participation, I agree to reimburse and indemnify the parish/school for all reasonable legal and court fees incurred by parish/school in defending a lawsuit that I or my child/ward may bring against the parish/school which relates to the above named activity if the parish/school is found not legally liable by the courts and prevails in the lawsuit. If the parish/school is found legally liable for injuries sustained by child/ward, this paragraph will not apply.

I certify that I have an understanding of this agreement and any risks and hazards associated with the activity described above that my child/ward will be participating in. I further understand that I had the opportunity to fully discuss this agreement with a representative of the parish/school to clarify any concerns or questions about the activity or this agreement that I may have had.

I have read the information above and give consent for my child to participate in all aspects of this field trip:

Photo Consent and Video Release

I, _____consent to the use by the ArchdioceseofMilwaukee and St. Mary parish, in Kenosha any videotape, photograph, slide, audiotape, or any other visual or audio reproduction in which I or my child may appear. I understand that these materials are being used for promotion of Office for Schools, Child and Youth Ministry or the above named parish/school. Such promotional activities extend to recruitment, fund-raising, advocacy, etc. I release the staff, volunteers, etc. of the ArchdioceseofMilwaukee or the above named parish/school from any liability connected with the use of my or my child's picture or voice recording as part of any of the above or similar activities.

My child may be pick up by the following individual(s):

NAME	RELATION TO CHILD	PHONE NUMBERS
1.		
2.		
3.		

PARENT/GUARDIAN SIGNATURE:	DATE: This form is valid for one year after date below

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Emergency Medical Treatment: In the event of an emergency, I give permission to transport my child to a hospital for emergency medical treatment. I wish to be advised prior to any further treatment by the hospital or doctor.

If we are unable to reach a parent/guardian at the above numbers, contact:

ALTERNATE CONTACT NAME:	PHONE:
PHYSICIAN'S NAME:	PHONE:
NAME OF MEDICAL INSURANCE:	POLICY #:
PERTINENT MEDICAL CONDITIONS, INCLUDING ALLERGIES AND SPECIAL DIETARY NEEDS:	

Other Medical Treatment: In the event that the child becomes ill with symptoms such as headache, vomiting, sore throat, fever, or diarrhea, do you grant permission for supervisors to give your child non-prescription medication, such as acetaminophen, throat lozenges, cough syrup, or antacid?

☐ Yes ☐ XNo, I wish to be contacted first.

Medications: List all medications, prescription and over-the-counter, that the student currently takes at home and during the school day. Include all as-needed (such as Ibuprofen) and emergency medications. Medications not authorized for self-carry must be in original container and given to the designated supervisor.

MEDICATION:	DOSAGE:	ROUTE: HOW GIVEN:	FREQUENCY:	START DATE:	STOP DATE:	SIDE EFFECTS:
1.						
2.						
3. 4						

MEDICAL PROVIDER CONSENT: REQUIRED FOR PRESCRIPTION MEDICATIONS LISTED ABOVE.

I Authorize the School/Parish to Give the Above Prescription Medication(S) to this Student.	
PRINT MEDICAL PROVIDER NAME:	PHONE:
MEDICAL PROVIDER SIGNATURE:	DATE:
Inhaler and Epi-Pen Only: This student and his/her parents have been instructed in self-administration and the student may carry an inhaler or Epi-Pen and self-administer. Yes☐ No☐	

PARENT CONSENT FOR MEDICAL TREATMENT AND ADMINISTRATION OF MEDICATION

I hereby warrant that to the best of my knowledge; my child is in good health and I assume all responsibility for the health of my child. I give the school/parish permission for emergency and other medical treatment, including the administration of the above prescription and non-prescription medication(s).	
PARENT/GUARDIAN SIGNATURE:	DATE:
Inhaler/Epi-Pen Only: My child may ☐ or may **not** ☐ carry and self-administer. CHILD'S NAME _____	

11/9/2026 2:05 PM