INDIVIDUAL PARTICIPANT PERMISSION FORM

AUTHORIZATIONS Required of all participants.

I hereby give permission for myself _____ to participate in the **St. Therese Vocation Retreat at Bishop Lane Retreat Center, June 23rd – June 26th, 2019,** I hereby release and indemnify the Diocese of Rockford, its staff and volunteers, all participating parishes and the Catholic Bishop of Rockford from any and all liability arising from claims of any kind or nature whatsoever from myself's participation in this program. I understand my child/self maybe photographed/video taped for promotion and coverage of this program by the Diocese of Rockford, as part of their participation, and I give permission for this.

_____ _____

Signature Date

_____ _____

Address City/State/Zip

**The purpose of this event is vocation awareness.*

MEDICAL PERMISSION FORM & INSURANCE INFORMATION

I grant permission for the administration of first aid to_____by the people in charge of the program and those transporting to and from the program as their judgement deems advisable, and to make the necessary referrals to qualified physicians for treatment of illness or accidents of a more serious nature. I understand that my emergency contact will be promptly notified in the event of any illness or accident and prior to any major surgery, except when delay in such communication would endanger life. In case of medical emergency, I understand that every effort will be made to contact the parents or emergency contact of the participant. In the event they cannot be reached I hereby give permission to the physician selected by the adult staff to hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery, if deemed necessary. The undersigned shall be liable and agree(s) to pay all costs and expenses incurred in connection with such medical and dental services rendered to the aforementioned pursuant to this authorization.

_____ _____

Signature Date

_____ _____

Physician Physician's Phone Number

INSURANCE INFORMATION

_____ _____

Insurance Company Policy in the Name of:

_____ _____

Policy Number I.D. # or Social Security #

Please list any **allergies or special medical problems** you may have.

Should it be necessary to return home due to medical reasons or discipline problems, the undersigned will be called and expected to pick up or make arrangements to be picked up immediately.

_____ _____

Signature Date

Vocation Retreat Registration Form

Please also complete the Permission Form below and mail both in as soon as possible.

Name: _____

Address: _____

City, State, Zip:_____ T-Shirt Size_____

Phone #: _____

Parish: _____

College: _____

Year entering: _____

Date of birth: _____

Email: _____

Health History

1. Does you have any health or other problems we should know about? Please explain:

_____

_____

_____

2. Does you take any medication? If so, what type, what is it for?

_____

_____

_____

3. In case of an emergency, please list two or three people and phone numbers for contact:

Name: _____ Phone #=s:_____

Name: _____ Phone #=s:_____

Name: _____ Phone #=s:_____

Suggested Donation:

	Suggested	Enclosed
4. Registration fee:	$90.00	_____

Please mail to: Vocation Office B 555 Colman Center Drive. - Rockford, IL, 61125.

For more information or questions contact the Vocation office:

Phone: 815-399-4300. E-mail: vocations@rockforddiocese.org

MAKE CHECKS PAYABLE TO: VOCATION OFFICE
P.O. Box, 7044
Rockford, IL 61125-7044

No one will be turned away for an inability to pay