

**Please fill out completely and kindly return to the Youth Ministry Office no later than January 29, 2012.**

**ARCHDIOCESE OF BALTIMORE  
DIVISION OF YOUTH & YOUNG ADULT MINISTRY  
PERMISSION FORM AND RELEASE**

Youth Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Parent Name: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Other number Parent can be reached: \_\_\_\_\_ E-Mail: \_\_\_\_\_

Home Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Male Female (please circle)

In consideration of the wholesome recreational and learning experience in which my son/daughter will participate, I as parent or guardian of my son/daughter, do hereby agree to allow my son/daughter to accompany the youth ministry/campus ministry group of their parish/school to:

**2012 CONFIRMATION RETREAT  
AT CAMP WABANNA RETREAT CENTER (Edgewater, MD)**

**Adult in Charge: Cassandra Anderson – 410-647-3346**

**Date/Time: February 3– 4; February 10-11; or February 11-12 (7:00 PM – 4:00 PM)**

**Meet: St. John's Parking Lot for Bus transportation to retreat**

I/we acknowledge receipt of the attached information sheet describing the planned activities. In consideration of the opportunity for my son/daughter to participate in the program, I agree to RELEASE AND HOLD HARMLESS AND INDEMNIFY **St. John the Evangelist Catholic Church**, the Division of Youth & Young Adult Ministry, the Roman Catholic Bishop of Baltimore and his successors, a Corporation Sole, and all their agents, servants and employees from any liability, claims, demands and causes of action arising out of or relating to any loss, damage or injury sustained in connection with or arising out of my son/daughter's participation in the program.

I hereby grant permission to any staff person to obtain medical care from a licensed physician, hospital, or medical clinic for my son/daughter in the event that I cannot be reached. (Check one of the following:)

- I am covered by hospitalization and medical insurance under policy # \_\_\_\_\_ issued by \_\_\_\_\_.
- I do not have medical coverage and assume responsibility for the cost of hospitalization and medical care for my son/daughter.

I hereby grant permission to any staff person to provide the following over-the-counter drugs (or their generic equivalent) to my son/daughter if requested by my son/daughter (Circle all that apply:)

Tylenol Benadryl Advil Sudafed Midol Kaopectate Neosporin Pepto Bismol

ADD any other medical information concerning medication, allergies, illness, etc. \_\_\_\_\_

ADD any dietary restrictions: \_\_\_\_\_

Parents/guardians of participants are advised that photographs or videotape of participants may be used in publications, websites or other materials produced from time to time by the Division of Youth and Young Adult Ministry or the Archdiocese of Baltimore. (Participants would not be identified, however, without specific written consent.) Parents/guardians who do not wish their child(ren) to be photographed or filmed should so notify the Division in writing. Please note that the Division has no control over the use of photographs or film taken by media that may be covering the event in which your child(ren) participate(s).

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Child's Name \_\_\_\_\_

**Yes, I am available to help CHAPERONE. Contact me at \_\_\_\_\_**