



Teen Retreat Participation/Emergency Medical Authorization Form
Children or Youth Activities



Dear Parents or Guardians,

In order for your son/daughter to participate in the activities below, our insurance company requires this form to be on file for every participant.

Son/daughter's name _____ Date of Birth ____/____/____

Home Address _____ City / State _____ Zip _____

Name of emergency contact: _____ Relation to son/daughter _____

Emergency phone # _____ Home phone # _____

Is sponsor, (*Immaculate Conception Church, Ithaca, NY*), authorized to approve medical treatment? ____ yes ____ no

Is participant covered by personal/family medical insurance? ____ yes ____ no

If yes, name of insurer _____ policy or group # _____

Participation Agreement

By signing below, the parent/guardian acknowledges and accepts the risks of physical injury associated with participation in the activities

listed below. Except for gross negligence on the part of the sponsor, the parent/guardian accepts personal financial responsibility for any bodily or personal injury sustained during the activities. Further, the parent/guardian promises to hold harmless and indemnify the sponsoring

organization and its representatives for any injury related to the activities and any associated fees and costs.

Activity: **High School Teen Retreat Sponsored by Immaculate Conception Church Held at Camp Casowasco**

If a dispute over this agreement or any claim for damages arises, the parent/guardian agrees to resolve the matter through a mutually acceptable arbitration process.

Signature _____ Date _____

(Parent or Guardian of minor)

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Part I Emergency Medical Agreement

In the event that I cannot be reached at _____ (phone #) or other parent _____ (phone #), I consent to the administration of any treatment deemed necessary by Dr. _____ (preferred physician) or Dr. _____ (preferred dentist). In the event that the above designated preferred medical practitioner is not available, I consent to the administration of any treatment deemed necessary by another licensed physician or dentist.

In the event that it is deemed necessary to transfer the child, my preferred hospital is; _____ although it may be necessary to transfer the child to another reasonable, accessible facility.

Note: This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists concur in the necessity of such surgery.

Signature _____ Date ____/____/____

Address _____ City/ State _____ Zip _____

Please list facts concerning the child's history, including allergies, medication being taken or any physical impairment to which a physician should be alerted. _____

PART II Refusal to Consent Agreement

Do not fill out Part II if you filled out Part I

Part II - Refusal to Consent Agreement

I DO NOT give my consent for emergency medical treatment of my child in the event of illness or injury requiring emergency treatment. I wish (*Immaculate Conception Church, Ithaca, NY*) staff or responsible leader to take no action.

Signature _____ Date _____

Address _____ City/State _____ Zip _____