

**ARCHDIOCESE OF BALTIMORE  
DIVISION OF YOUTH & YOUNG ADULT MINISTRY  
PERMISSION FORM AND RELEASE – Due October 7, 2012**

**CONFIRMATION RETREAT**

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

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

**Other number where Parent can be reached:** \_\_\_\_\_

**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 St. Isaac Jogues Confirmation group to:  
**Confirmation Retreat at Msgr. O'Dwyer Retreat House, Sparks MD on:**

**December 7 – 9, 2012, 7:00 p.m. Friday to 12:00 p.m. Sunday.**

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. Isaac Jogues Church, Ken Goedeke, the Division of Youth & Young Adult Ministry, the Roman Catholic Bishop of Baltimore and his successors, a corporate 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 to my son/daughter if requested by my son/daughter. (Check all that apply:)

- Tylenol  
 Benadryl  
 Advil  
 Sudafed  
 Midol  
 Kaopectate  
 Neosporin

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

Add any dietary restrictions: \_\_\_\_\_

**Date:** \_\_\_\_\_ **Parent/Guardian Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_ **Parent/Guardian Signature:** \_\_\_\_\_

**Youth's Signature:** \_\_\_\_\_