CREDO 2018

MY NAME IS: Jesus

Lamb Emmanuel RABBI King Lord of Redeemer MESSIAH Bread SAVIOR Prince Teacher LION SON Bridegroom Nazarene Son of God OF MAN

4/13-
4/15
2018

High School Retreat

Association Retreat Center

$90 - Cost

Register by 3/4

CONTACT
Eric Duffy
763-862-4333
eduffy@epiphanymn.org

EPIPHANY

DUE: With Payment, on Mar 4th 2018

CREDO

Cost is $90. No form will be accepted w/o payment ***(If you attended FIDEI, Cost is $70)***

An Epiphany High School Youth Ministry Retreat on April 13-15, 2018

FIELD TRIP PARENTAL CONSENT FORM & INDEMNITY AGREEMENT

Student/Participant Name _____
Date of Birth _____ Gender: M or F? _____ T-Shirt Size: **S - M - L - XL - XXL**
Parent/Guardian Name _____
Home Address _____
Home Phone _____ Cell Phone _____ Email:_____

Date of Event/Field Trip___April 13-15, 2018____ Type of Field Trip _____Retreat_____
Destination _____Association Retreat Center in Osceola, WI

Individual(s)/Teacher(s) in Charge _____Eric Duffy, Epiphany High School Youth Minister_____
Estimated Time of Departure __Meet at 6pm, Friday (Eat Before!)____ Return ___12:00pm Sunday
(We have mass on Retreat)

Mode of Transportation To & From Event _____Bus_____
Student Cost (if applicable) _____$90_____

I, _____, grant permission for _____ Parent or
Guardian Name *Child Name*
to participate in the above named activity and I warrant that my child is in good health. In consideration of my child's participation, I agree to indemnify **The Church of the Epiphany** and the Archdiocese of St. Paul & Minneapolis from any claims or law suits brought against the **The Church of the Epiphany** /Archdiocese of St. Paul & Minneapolis by myself, my child or others, that arises out of any behavior by my child at the event/activity described above. I also agree to pay reasonable attorney's fees or expenses incurred by the parish/school and the Archdiocese in defense of such a claim/suit.

EMERGENCY MEDICAL TREATMENT: In the event of an emergency, I give permission to transport my child to a hospital for medical treatment. I wish to be advised prior to any further treatment by a doctor or hospital. In the event of any emergency, if you are unable to reach me at the above numbers, contact

_____ _____
Name Phone Number

OPTIONAL MEDICAL INFORMATION:
Medication my child is taking at present _____
Allergies _____
Other Medical Conditions_____
Family Health Plan carrier number _____
Family Doctor _____ Phone Number _____

As Parent or Guardian, I agree to all of the above stated considerations and conditions.

_____ _____
Signature Date