

TEEN RETREAT
PART "A"

TEEN ACTS RETREAT
Adoration, Community, Theology, Service
Retreat Registration/Consent and Liability Waiver Form

Please Print

Minor Participant's Name: _____
Home address: _____ City/State/Zip: _____
Home Phone: _____ E-mail Address: _____
Date of Birth: _____ Age: _____ T Shirt Size (Adult Sizes) _____
Sex: _____ Grade: _____ School: _____

Parent or Guardian's Name: _____ Home phone: _____
Business Phone: _____ Cell Phone: _____

I, _____ grant permission for my teen, _____
to participate in this youth ministry event. This activity will take place under the guidance and direction
of adult and youth volunteers of the ACTS Community.

The Teen ACTS retreats' goals are to deepen one's relationship with Jesus Christ through interaction of
youth and adults including religious, spiritual, moral, and social issues, through prayer and scripture
sharing, and through physical games and exercises.

The Teen retreat begins at the Bishop DeFalco Retreat Center 2100 N. Spring in Amarillo on Thursday
evening and ends on Sunday following the closing Mass and reception. The cost for the retreatant is
\$150.00.

As the parent and/or legal guardian, I remain legally responsible for any personal actions taken by the
above named minor "participant".

I agree on behalf of myself, my teen named herein, our heirs, successors and assigns to hold harmless and
to defend the Bishop DeFalco Retreat Center, its officers, directors and agents, the Diocese of Amarillo,
and ACTS volunteers from any and all liability for illness, injury or death arising from or in connection
with my teen attending the above named event and I agree to compensate the retreat center, its officers,
directors and agents and the Diocese of Amarillo or representative associated with the event for
reasonable attorney's fees and expenses in connection therewith.

Parent or Guardian Signature: _____

A prompt response is recommended because registrations are made on a first received, first served basis regardless of when
your name was submitted or if you are prepaid. You will receive a letter two weeks before the retreat describing what you
will need to bring for the retreat. For further retreat or registration information, contact David at 356-8325.

PLEASE NOTE: Financial difficulties should not prevent anyone from attending the retreat. If you are unable to pay the
entire fee, financial arrangements can be made by contacting the ACTS Core President, Davlyn Duesterhaus at 212-8778.

Youth Signature: _____

Please mail your registration form **(PARTS A AND B)** to:
ACTS Retreat
P.O. Box 30701 Amarillo, TX 79120

PLEASE INCLUDE THE FEE OF \$150.00
(A minimum deposit of \$75.00 is required to be put on the list; the entire \$150.00 is due before the retreat.)

Make checks payable to: ACTS Retreat
If cancellation is made within one week of the retreat, \$50 of the retreat fee will be retained.

TEEN ACTS RETREAT

MEDICAL CONSENT AND PERMISSION TO TREAT

To the best of my knowledge, my teen, _____, is in good health, and I assume all responsibility for the health of my teen. **Emergency Medical Treatment:** In the event of an emergency, I hereby grant permission to transport my teen to a hospital for emergency medical treatment. ____ **Yes** ____ **No** (Preferred Hospital _____)
I wish to be advised prior to any further treatment by the hospital or doctor. ____ **Yes** ____ **No**

Parent/Guardian's Name: _____
Home Address: _____
Home Phone: (____) _____ Business Phone: (____) _____
Cell Phone: (____) _____ Pager: (____) _____
If you are unable to reach me, please contact:
Name: _____
Relationship to me or my teen: _____
Home Phone: (____) _____
Business Phone: (____) _____

Family Doctor: _____
Phone number: _____

Please include a photocopy of your Insurance Card (front and back).

- Insurance Carrier: _____ Policy Number _____
- My teen is taking medication and will bring all of the medicines in their original containers.
- I hereby grant permission for non-prescription medication (such as cough drops, cough syrup, Tylenol, etc.) to be given to my teen if necessary: ____ **Yes** ____ **No**
- I understand that aspirin will not be given to my teen without express permission. I hereby grant such permission: ____ **Yes** ____ **No** My teen is allergic to the following (medications, foods, plants, insects, etc.) _____
- My teen's immunizations are current and up to date: ____ **Yes** ____ **No**
- My teen's last tetanus/diphtheria immunization: _____
- My teen has the following physical limitations: _____
- My teen experiences homesickness, emotional reactions to new situations, sleepwalking, fainting, bed wetting, etc. ____ **Yes** ____ **No** If Yes, please explain: _____
- My teen has recently been exposed to a contagious disease or condition such as mumps, measles, chickenpox, etc. ____ **Yes** ____ **No** If yes, please state the date and disease or condition: _____
- My teen is suffering from a psychological condition which may affect or limit his or her ability to participate in this activity. ____ **Yes** ____ **No** If yes, please explain. _____

Signature of Parent or Guardian

Date