

Grade School Program (grades 1-6)  
Monday, June 17 to Friday, June 21, 2019  
9:00 a.m. – 3:00 p.m.  
Bring a sack lunch & water bottle daily  
Cost is \$20.00 per student.

"Twilight Retreat" (grades 7-12)  
Sunday, June 16 to Thursday June 20, 2019  
7:30 p.m. – 9:30 p.m.  
Cost is \$20.00 per student.

## Totus Tuus

### Registration & Parental/Guardian Consent Form and Liability Waiver

Participant Name \_\_\_\_\_  
*First Middle Last*

Home address \_\_\_\_\_  
*Street City State Zip*

Birth date \_\_\_\_\_ Sex \_\_\_\_\_ Grade for next School Year \_\_\_\_\_

Parent/Guardian Name \_\_\_\_\_

Home Phone \_\_\_\_\_ Business Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

As 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 child named herein, or our heirs, successors, and assigns, to hold harmless and defend (name of parish/school), its officers, directors, employees and agents, and The Diocese of Sioux City, its employees, and agents and chaperones, or representative associated with the event for reasonable attorney's fees and expenses which may incur in any action brought against them as a result of such injury or damage, unless such claim arises from negligence of the parish/school/diocese.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_ **(Please Initial) Photo Release:** Pictures of my child taken during the event may be used in print or electronic media for the purposes of publicity for future events, unless I indicate to the Diocesan Director of Religious Education in writing to the contrary.

**MEDICAL MATTERS:** I hereby warrant that to the best of my knowledge, my child is in good health, and I assume all responsibility for the health of my child. (Of the following statements pertaining to medical matters, sign only those that are applicable.)

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

#1 Contact Name & Relationship \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

#2 Contact Name & Relationship \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Family Doctor \_\_\_\_\_ Phone \_\_\_\_\_

Family Health Plan Carrier \_\_\_\_\_ Policy # \_\_\_\_\_

**Other Medical Treatment:** In the event it comes to the attention of the parish, its officers, directors and agents, and the Diocese of Sioux City, chaperones, or representatives associated with the activity that my child becomes

ill with symptoms such as headache, vomiting, sore throat, fever, diarrhea, I want to be called collect (with phone charges reversed to myself).

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Medications:** My child is taking medication at present. My child will bring all such medications necessary, and such medications will be well-labeled. Names of medications and concise directions for seeing that the child takes such medications, including dosage and frequency of dosage, are as follows:

\_\_\_\_\_  
\_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

No medication of any type whether prescription or non-prescription, may be administered to my child unless the situation is life-threatening and emergency treatment is required.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**OR:**

I hereby grant permission for non-prescription medication (such as non-aspirin products, i.e. acetaminophen or ibuprofen, throat lozenges, cough syrup) to be given to my child, if deemed appropriate.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Specific Medical Information:** The parish/school will take reasonable care to see the following information will be held in confidence.

Allergic reactions (medications, foods, plants, insects, etc.) \_\_\_\_\_  
\_\_\_\_\_

Does your child have a medically prescribed diet? \_\_\_\_\_  
\_\_\_\_\_

Any physical limitations? \_\_\_\_\_  
\_\_\_\_\_

Has child recently been exposed to contagious disease or conditions such as mumps, measles, Chicken pox, etc.?

If so, list date and disease or condition \_\_\_\_\_

You should be aware of these special medical conditions of my child: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_