STM Quest Retreat Registration: 2021

PARTICIPANT INFORMATION:

Participant Name (Print): _____
(LAST) (FIRST) (M.I.)

Sex: FEMALE ☐ MALE ☐ **Grade Level:** 9 ☐ 10 ☐ 12 ☐

T-shirt size: _____

Age:_____ **Birthday:**_____

Primary Mailing Address: _____

_____

Home Phone Number: _____ **Cell phone number**: _____

MOTHER (Female Guardian) Name: _____

Work phone number: _____

Cell phone number: _____

E-mail address: _____

FATHER (Male Guardian) Name: _____

Work phone number: _____

Cell phone number: _____

E-mail address: _____

RETREAT PAYMENT:

A payment of **$160.00** is due with this registration form. Students will not be able to attend retreat until all fees have been paid and this form is completed and submitted to STM Campus Ministry Leadership. This fee is non-refundable two weeks prior to the retreat date indicated on this form. A "What to Bring" list will be e-mailed the week before the scheduled retreat. If you are in need of financial assistance, contact Lance Strother (lance.strother@stmcougars.net) or at 337-322-6274.

MEDICAL INFORMATION AND PARENTAL/GUARDIAN CONSENT FORM/LIABILITY WAIVER

I, (parent/guardian name)_____ grant permission for my child, (participant's name) _____ to participate in this school event.This activity will take place under the guidance and direction of school employees and volunteers from St. Thomas More Catholic High School.

Description of activity:

- Type of event: STM Quest Retreat
- Date of event: September 25th - 26th
- Location: Dry Creek Baptist Camp
- Individual in charge: Lance Strother
- Arrival: Arrive to STM @6:30am, Sept. 25th
  Return to STM @2:30 pm Sept. 26th
- Transportation: School Bus

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 St. Thomas More Catholic High School, its officers, directors, employees and agents, chaperons, or representatives associated with the event, from any claim arising from or in connection with my child attending the event or in connection with any illness or injury (including death) or cost of medical treatment in connection therewith, and I agree to compensate the school, its officers, directors and agents, and the Diocese of Lafayette, LA, its employees and agents and chaperons, 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 the negligence of the school or Diocese of Lafayette, LA.

Parent/Guardian signature:_____ Date:_____

Medical:

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. He or she is not showing any COVID-19 Symptoms below:

Fever or chills

Cough

Shortness of breath or difficulty breathing

Fatigue

Muscle or body aches

Headache

New loss of taste or smell

Sore throat

Congestion or runny nose

Nausea or vomiting

Diarrhea

Parent/Guardian Signature:_____

(1) ***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:
Name of Emergency Contact & relationship:_____
Emergency Contact Phone:_____
Family doctor:_____ Phone:_____
Family Health Plan Carrier:_____ Policy #:_____
Parent/Guardian signature:_____ Date:_____

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(2) ***Other Medical Treatment:*** In the event it comes to the attention of the school, its officers, directors and agents, and the Diocese of Lafayette, La, chaperons, 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 (with phone charges reversed to myself).

Parent/Guardian signature:_____ Date:_____

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(3) ***Medications:*** My child is taking medication at present. My child will bring all such medications necessary and such medication 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: _____
_____
(*If child is* ***not*** *taking medication, write* ***NA*** *in blank above and sign below*)

Parent/Guardian signature:_____ Date:_____

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(4) PLEASE CHECK <u>ONE</u> OF THE FOLLOWING and SIGN BELOW:
_____ 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.
_____ I hereby grant permission for non-prescription medication (i.e. non-aspirin products such as acetaminophen or ibuprofen, throat lozenges, cough syrup, etc) to be given to my child, if deemed appropriate.

Parent/Guardian signature:_____ Date:_____

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(5) ***SPECIFIC MEDICAL INFORMATION*****:** The school will take reasonable care to see that the following information will be held in confidence.
Allergic reactions (medications, foods, plants, insects, etc.):_____
Immunizations: Date of last tetanus/diphtheria immunization:_____
Does child have medically prescribed diet:_____
Does child have any physical limitations:_____
Is child subject to chronic homesickness, emotional reactions to new situations, sleepwalking, bedwetting, fainting?_____
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:_____

_____

Parent/Guardian signature:_____ Date:_____