WOJTYLA DAY
REGISTRATION AND PARENT/LEGAL GUARDIAN
PERMISSION AND INDEMNITY AGREEMENT

Location: Saint Francis de Sales Seminary

Supervisor of Event: Fr. John Burns, Milwaukee seminarians, and Vocation Office staff

Type of Event: Wojtyla Day

Date of Event: April 17, 2021, 9am-5:30pm

Method of Transportation: Participant/parents to provide morning arrival at St. Teresa of Calcutta Parish Monches (W302 N9583 O Neil Rd, Hartland, WI 53029) and evening pick up at Holy Hill.

Name of Son/Ward: _____ Birthday: _____

Parish/School: _____ Grade: _____

I consent to the participation of my SON /WARD in the above named ACTIVITY.
In consideration for my SON /WARD's participation, I agree to reimburse and indemnify **St. Francis de Sales Seminary** (understood to include the Archdiocese of Milwaukee and Holy Hill) for all reasonable legal and court fees incurred by **St. Francis de Sales Seminary** in defending a lawsuit that I or my SON /WARD may bring against **St. Francis de Sales Seminary** which relates to the above named ACTIVITY if St. Francis de Sales Seminary is found not legally liable by the courts and prevails in the lawsuit. If **St. Francis de Sales Seminary** is found legally liable for injuries sustained by SON/WARD, this paragraph will not apply.

I certify that I have an understanding of this agreement and any risks and hazards associated with the ACTIVITY described above that my SON/WARD will be participating in. I further understand that I had the opportunity to fully discuss this agreement with a representative of **St. Francis de Sales Seminary** to clarify any concerns or questions about the ACTIVITY or this agreement that I may have had.

PARENT/GUARDIAN'S NAME(S): _____

HOME ADDRESS: _____

HOME PHONE: (____)_____ BUSINESS PHONE (____) _____

E-MAIL ADDRESS: _____

Signature_____ Date _____

OPTIONAL: If different from above or reverse side:

OTHER PARENT/GUARDIAN'S NAME: _____

OTHER HOME ADDRESS: _____

HOME PHONE: (____)_____ BUSINESS PHONE (____) _____

E-MAIL ADDRESS: _____

The other side of this form must be filled out and signed.

MEDICAL RELEASE FORM

St. Francis de Sales Seminary does not provide health or accident insurance for retreat participants. Parent/Guardian will be responsible for any medical treatment.

PARTICIPANT'S NAME:_____ BIRTH DATE: _____ SEX: _____

FAMILY DOCTOR: _____ PHONE:(____)_____

Family Health Plan Carrier: _____ Policy Number: _____

MEDICAL MATTERS: I hereby warrant 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 IN ACCORDANCE WITH YOUR WISHES.

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 & RELATIONSHIP: _____

HOME PHONE: (____)_____ BUSINESS PHONE:(____)_____

Signature _____ Date _____

Other Medical Treatment: In the event it comes to the attention of DESIGNATED SUPERVISOR or staff that SON/WARD becomes ill with symptoms of headache, vomiting, sore throat, fever, or diarrhea, I DO want to be called.

Signature _____ Date _____

Medications*:* SON/WARD is taking medications at present and will bring the medication in the original container**, and only the number of doses necessary for the duration of this activity.** I give permission for SON/WARD to take this medication on his/her own. The dosage and frequency of dosage is as follows:

_____

Signature _____ Date _____

Over-the counter medication: Any over–the-counter medication, such as: aspirin, ibuprofen, Tylenol, cough drops, etc must come from home. No over-the-counter medications will be dispensed to SON/WARD.

Specific Medical Information: St. Francis de Sales Seminary will take reasonable care to see that the following information is held in confidence.

Allergic reactions (medications, foods, plants, insects, etc.): _____

Does child have a medically prescribed diet? _____

Any physical limitations or health concerns? _____

Is child subject to chronic homesickness, emotional reactions to new situations, sleepwalking, bedwetting, fainting?_____

Please complete this form return to:
Vocation Office
Saint Francis de Sales Seminary
3257 South Lake Drive
St. Francis, WI, 53086