Capuchin Youth & Family Ministries

P.O. Box 192, Garrison, NY 10524
Phone 845 424-3609 Fax 845-424-4403

7th & 8th Grade Overnight Retreat *(Morality)*

Please select which Retreat you would like to attend. The Registration deadline for either retreat is Tues, Jan. 23, 2012

_____ Fri., Jan. 27- Sat., Jan. 28, 2012 **_____Sat., Jan. 28 - Sun., Jan. 29, 2012**

Name:_____
Last First Middle Initial Name Tag Name

Address:_____
Number & Street City/Town State Zip

Phone: _____ E-Mail: _____ Parish_____
(Area Code) Number Please print **Clearly** zero:Ø, I, i L, l, O, o Parish Name City State

Age: ____Date of Birth: ___/____/_____Sex: ❑ M ❑ F Grade: ___ School: _____

High School Graduation Date: _____

Parent's Name: _____ Parent's E-Mail:_____

Allergies _____ Medication _____

EMERGENCY PHONE _____ CELL PHONE _____ EMAIL_____

*The total cost for this overnight is $75. A **non-refundable deposit** of $40 (checks made payable to Capuchin Youth & Family Ministries) and **original application** must be received by CYFM by the Tuesday before the retreat. The first retreat begins Fri. Jan. 27, 7:00pm and ends Sat. Jan. 28, 4:00pm. The second retreat begins Sat. Jan. 28, 7:00pm and ends Sun. Jan. 29, 4:00pm.*

Parent/Guardian Permission:

I give my son/daughter _____ permission to attend the 7th & 8th Grade Retreat at Capuchin Youth & Family Ministries (CYFM). I agree to waive and relinquish all claims I may have against Capuchin Youth & Family Ministries/Province of St. Mary of the Capuchin Order, and its officers, agents, volunteers, employees and volunteers as a result of my son/daughter's participation in this program.

We prefer that participants do not bring cell phones on the retreat. If you do, please know that Cell Phones will be collected during sleeping hours. If family needs to make emergency contact during sleeping hours they can call (845) 424-3609 ext 245 or ext 247 where one of the staff sleeps. During the day they can call (845) 424-3609 ext 241(our conference room extension).

I further agree to indemnify, hold harmless and defend Capuchin Youth & Family Ministries/Province of St. Mary of the Capuchin Order, its volunteers and employees from any and all claims resulting from injuries, including death, damages and losses sustained by my son/daughter and arising out of, connected with, or in any way associated with their activities during their participation in this program.

Medical Matters:

I hereby warrant that to the best of my knowledge, my son/daughter is in good health, and I assume all responsibility for the health of my child.

I hereby grant the adult leaders of this retreat full authority to take whatever action they consider to be warranted under the circumstances regarding my son/daughter's health and safety and I fully release each of them for any liability for such actions taken on my son/daughter behalf. This authority will permit the adult leaders, at their discretion, to place my child at my expense in a hospital at any point for medical treatment, or if no hospital is available, to place my child in the hands of a local medical doctor for treatment.

I hereby certify that I am the parent or guardian of the applicant named above; that I have read the above release statements; that I join in the release without reservation, granting my full consent to all actions provided for; and further agree to hold blameless CYFM, against any and all claims on behalf of the applicant.

Photo Release:

I hereby consent to and authorize the use and reproduction, in print or electronic format, by Capuchin Youth & Family Ministries or anyone authorized by Capuchin Youth & Family Ministries, of any and all photographs of my child taken at any CYFM events for any publicity purposes, without compensation. CYFM reserves the right to use these photographs in any of its print or electronic publications. All images – electronic or negatives and positives, together with the prints – are owned by CYFM.

I hereby warrant that I have read and understood all of the above-mentioned material.

Name & relationship_____ Phone Number_____

Family Doctor & Phone: _____

Family Health Plan Carrier: _____ Policy # _____ ID # _____

Signature: _____ Date: _____

Office Use Only:
Date Received _____ Deposit _____ Full Payment _____Processed By_____