

St. Edward the Confessor High School Youth Group

PERMISSION SLIP

OVERNIGHT RETREAT

Jan. 23-25, 2009

Participant's Name: _____

Parent/Guardian Name: _____

Address: _____

Home Telephone # _____

Cell Phone # _____

Date of Birth: _____ M _____ F

Name of Medical Insurance Plan: _____

Member Name _____

Group ID # _____

Member ID # _____

Phone # (for plan certification/authorization) _____

Emergency Contact: _____

Telephone # _____

Release/Authorization:

I authorize the High School Youth Group of St. Edward the Confessor, Bowie, Maryland to obtain medical/hospital treatment in the event of an emergency, and I understand that the High School Youth Group of St. Edward the Confessor, Bowie, Maryland will not be held responsible for any loss or damages that may result from said treatment.

(Signature of participant) (Date) (Signature of Parent/
Guardian) (Date)

Participants will not consume drugs or alcohol. The Parent/Guardian will be called and will need to pick up the participant at the event location.

(Signature of participant) (Date) (Signature of Parent/
Guardian) (Date)