



8th grade Confirmation Retreat

This is required!

Friday-Saturday, October 14 – 15 at TRINITY
6:30 p.m. – 8:30 a.m.

EAT BEFORE YOU COME TO THE RETREAT

Be sure to bring: sleeping bag, pj's, personal items, toothbrush, toothpaste, change of clothing.

This slip needs to be turned in now or by **Wednesday, October 12.**

Questions? Call 257-5129, ext. 23 or e-mail linda@trinitylindstrom.org

✂ ✂ **Tear off below:**

PERMISSION / CONSENT FORM: I hereby give my consent to have my minor child,

_____ participate in the 8th grade Confirmation Retreat at Trinity on October 14-15, 2016 with Trinity Lutheran Church, Lindstrom, MN.

I recognize that there are risks involved in participating in this activity with Trinity Lutheran Church and hereby assume all risk of injury, harm, or damage to my minor child as they participate in this activity. I hereby release and agree to hold harmless Trinity Lutheran Church and its employees, organizers, and any volunteers assisting in the program, from any and all liability and claims arising out of my child's participation in programs and related activities. I hereby release Trinity Lutheran Church, its staff and sponsors, from responsibility and liability for any injury or illness that my child may sustain during the event.

In case of emergency, where I cannot be reached, I hereby authorize Trinity Lutheran Church to administer necessary first aid or seek emergency medical attention for my child. I hereby authorize an adult leader of this event, as agent for me, to consent to any x-ray examination; medical, dental or surgical diagnosis; treatment; and/or hospital care advised and supervised by a physician, surgeon, or dentist (as appropriate) licensed to practice under the laws of the state where the services are rendered, either at the doctor's office or in any hospital. I expect to be contacted as soon as possible. I understand that I am responsible for the health care decisions of my minor child and agree that my insurance plan is the primary plan to pay for the medical, dental, or hospital care or treatment that is given to my minor child.

I give my permission for my child to be photographed/videotaped. I understand that the images may be displayed in church publications, church building, website and/or social media. I understand that as a precaution, my child's names will NOT be published or linked with photographs.

Date _____

Signature of Parent/Guardian _____

EMERGENCY INFORMATION: In case of emergency, please contact (when parent/guardian cannot be reached):

Name _____

Phone(s) _____

MEDICAL INFORMATION:

DOCTOR _____ Phone _____ or

CIRCLE ONE: C. L. Clinic 651-257-8400 ♦ Fairview-Wyoming 651-982-7000 ♦ St. Croix Clinic 1-800-642-1336

Please list any allergies _____

Medications being taken _____

Medical/dietary needs _____

Physical handicaps or limitations _____

Medical insurance company _____ Policy# _____ Group # _____

Parents:

Would you be willing to help with the whole retreat? yes _____ no _____

Would you be willing to help from 6:30 – 10:30 pm? yes _____ no _____

from 10:00 p.m.–1:00 am? yes _____ no _____

with breakfast 7:30–8:30 am? yes _____ no _____

← **We need at least 10 - 12 adults to help!**