QUO VADIS RETREAT
SEPTEMBER 8,9 &10

DIOCESE OF BAKER RETREAT CENTER | POWELL BUTTE, OR

Please complete and return the Registration and Medical Release Forms **by August,30 2017**.

Mail registration to: Diocese of Baker • Attn: 2017 Quo Vadis Retreat
Fax: 541-388-2566 Mail: 641 SW Umatilla Ave • Redmond, OR 97756

Name ____
Please Print
Address ____

City ______________________________ State _______ Zip Code ___________________

Home Phone ____________________________ Cell Phone ________________________

Email ____

Parish _________________________________ City _____________________________

RELEASE OF ALL CLAIMS

In consideration of the permission granted to the above named by _______________________________________ (your name) to participate in Quo Vadis Retreat, I hereby release the Bishop of the Diocese of Baker, the Diocese, its agents and employees from all action, causes of actions, or damages claims, demands which I, my heirs, executors, administrators, or assigns may have against the Diocese of Baker and other above described parties, for all personal injuries or to other claims for relief known or unknown which may incur by participating in the above described activity/event and which would normally occur as an assumed risk of participating in said activity or activities. I agree to compensate the parish, its officers, directors and agents and the Diocese of Baker, its employees and agents and chaperones, 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 parish/diocese. I, the undersigned, have read this release and understand all its terms. I execute it voluntarily and with full knowledge of its significance. In witness whereof, I have executed this release on the _____ day of ____________ 20___.

Signature ____ Date ___________________________

****Please list any food allergies. We'll try to accommodate your dietary needs.**

Food Allergies:____

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT AND RELEASE OF ALL CLAIMS

For Youth attending ___________________________________ (name of event). To be completed by parent/guardian of minor.

Name ____ Birthdate ____/____/____ Sex _____ Age _____

Last First Initial

Father/Guardian ____ Home Phone ___________________________________

Mother/Guardian ____ Home Phone ___________________________________

Father Cell Phone _____________________________ Mother Cell Phone ________________________

Home Address ____

City State Zip Code

NON-EMERGENCY ILLNESS/INJURY: Illness or injuries which occur while attending camps at the Diocese of Baker Retreat Center will be addressed according to the Physician's Treatment Procedures. Please contact the Chancery Office to request a copy. There will not be a designated physician available on site or by phone for camps. Camp medical personnel (RN or EMT) will notify parents and call 911 for medical conditions beyond the scope of the protocol and arrange transport as indicated.

Food Allergies/Needs _______________________________________ Drug Allergies __________________________________
Disability/Chronic Illness ____
Are there any activities your child should be excluded from for any reason? ____

Is child taking medication prescribed by a physician now? Yes ____ No ___ Please list all medications prescribed, the size of dose, and when it is to be taken. Keep it in the original packaging/bottle that identifies the prescribing physician, the name of the medication, the dosage, and the frequency of administration.

All Medication must be given to the Nurse and will be dispensed according to directions and by the Nurse.

Med #1 ___________________________ Dosage __________________ Specific time taken each day _____________________
Reason for taking ____
Med #2 ___________________________ Dosage __________________ Specific time taken each day _____________________
Reason for taking ____
Med #3 ___________________________ Dosage __________________ Specific time taken each day _____________________
Reason for taking ____

EMERGENCY TREATMENT: I, as parent or guardian of participant, give my consent for the administration of any emergency treatment deemed necessary by a registered nurse, EMT, licensed physician or dentist; and the transfer of the minor to any hospital reasonably accessible when medically necessary. This authorization does not cover major surgery unless the medical opinion of two other licensed physicians concurring in the necessity for such surgery are obtained prior to the performance of such surgery.

Family Physician ____ Phone __________________________________

Dentist ____ Phone _____________________

Do you carry medical/hospital insurance? No ___ Yes ___ If yes, Please indicate:

Company ____ Policy/Group# ________________________________

PROMOTION PERMISSION

I, ___________________________________ (parent or legal guardian) ☐ DO ☐ DO NOT (check one) give my permission for above named youth's image to appear on the Diocese of Baker website or in future promotional publications for the Diocese.

RELEASE OF ALL CLAIMS

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 the Diocese of Baker and its officers, directors, employees, 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 officers, directors and agents of the Diocese of Baker its employees, agents, chaperons or representatives 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 Diocese.

Parent/Guardian's Signature ____ Date ________________________