



What's your

faithbook



Status?

Winter Retreat 2010

February 26-28

Camp Kirkwood

**Registration deadline is February 21.
See release form on back of this flyer.**

Get
"in a relationship"
with Jesus!

Information

Date:
Feb 26-28, 2010

Place:
Camp Kirkwood,
Wilmington

Who's Invited:
All 9th-12th graders

Cost:
\$65 (scholarships available)

Bring a friend and a snack
to share



The more the merrier!

👍 Like

Leave your valuables and
electronics (i-pods, cell
phones) at home



Give yourself some time with
God and others

👍 Like

Money-back guarantee



If you're not completely satisfied
by the end of the weekend, we'll
give you your money back!

Honest.

👍 Like

OFF-SITE & ONE-TIME ACTIVITY RELEASE & MEDICAL INFO

Church of the Ascension 2025 Woodman Dr, Kettering OH 45420 www.ascensionkettering.org

ACTIVITY: Winter Retreat COST: \$65 (scholarships are available)
LOCATION: Camp Kirkwood, Wilmington EMERGENCY PHONE: (937)344-7772
START DATE/TIME: 5:45 PM Friday, February 26 MEETING PLACE: Ascension Church
END DATE/TIME: About 2:00 PM Sunday, February 28 LEADER: Joe Ollier TEL: Cell:251-4599
TRANSPORTATION: Parent Drivers needed EMAIL: jollier@ascensionkettering.org
TYPE OF ACTIVITIES: small and large group discussions and activities, witness talks, Reconciliation, Mass
OTHER INFORMATION: Pleas bring a snack to share. Leave all valuables, electronics (i-pods, cell phones, etc...) at home

----- PARENTS: KEEP TOP for your records, RETURN BOTTOM of form -----

ARCHDIOCESE OF CINCINNATI Event: Winter Retreat
PERMISSION, RELEASE AND MEDICAL POWER OF ATTORNEY Date: February 26-28, 2010

1. I, the lawful parent or guardian of _____ (the "child"), give permission for my child to participate in the activity described on the reverse and release from all liability and indemnify the Archbishop of Cincinnati ("the Archbishop"), both individually and as trustee for the Archdiocese of Cincinnati and all parishes within the Archdiocese, and their officers, agents, representatives, volunteers, and employees from any and all liability, claims, judgements, cost or expenses, including attorney fees, arising out of any injury or illness incurred by my child while participating in or traveling to or from the activity.

2. I agree to instruct my child to cooperate with the Archbishop or his agents in charge of the activity.

3a. I appoint the Archbishop or his agents who are acting as leaders of the activity as my attorney in fact to act for me in my name and my behalf, in any way that I would act if I were personally present, with respect to the following matters if any injury, illness or medical emergency occurs during the activity or related travel:

(i) To give any and all consents and authorizations to any physicians, dentist, hospital or other persons or institutions pertaining to any emergency medications, medical or dental treatments, diagnostic or surgical procedures or any other emergency actions as our attorney shall deem necessary or appropriate for the best interest of the child.

(ii) I understand that the agents of the Archbishop will make a reasonable attempt to contact me as soon as possible in the event of a medical emergency involving my child.

3b. This power of attorney shall lapse automatically upon completion of the activity and related travel.

4. I agree that the Archbishop or his agents may use my child's portrait or photograph for promotional purposes, website and office functions.

I have carefully read this statement, and my signature acknowledges that I fully understand the content and meaning.

Parent/Guardian Signature _____ Date ____/____/____
Home Address _____ City _____ Zip _____
Parent E-mail _____ Youth E-mail _____
Phone (H) _____ (W) _____ (C) _____
Youth Cell _____ Youth School _____ HS year of graduation _____
Emergency Contact _____ Phone (H) _____ (W) _____ (C) _____

MEDICAL INFORMATION -- Completed By Parent/Guardian -- Please Print

Child's Name _____ Birthdate ____/____/____
Allergies & Recommended Treatment _____
Medications, Times, Dosages _____
Medication may be administered by (circle all that apply): My child chaperones
Chronic Conditions (e.g. epilepsy, diabetes) _____
Medical Insurance Co. _____ Policy Number _____
Member's Name _____ Hm Phone _____ Wk Phone _____
Member's Birthdate ____/____/____
Family Doctor _____ Phone _____

____ I can Drive/Chaperone (____ # passengers w/ seatbelts) OFFICE USE: Paid _____ Check # _____