



# Year of Teens and Young Adults

July 2011 - June 2012

## YOUR VOICE COUNTS!

Join the **CONVERSATION** by sharing your Ideas, Hopes and Dreams for the future

This invitation is coming to you because we believe you are a young leader that wants more for your life and the lives of other young Catholics.

*Join us to plan and share your ideas!*

Where: .....

Date: .....

Time: .....

Cost: **FREE!** .....

To register complete the **Permission Form** (on the reverse) and submit it

to: .....

.....

by: .....

*Snacks and drinks for everyone!*



Youth Permission Form Completed by Parent/Guardian for

## CONVERSATIONS WITH TEENS

**THE FOLLOWING FORM MUST BE COMPLETED FOR EACH PARTICIPANT**

I give permission to my son/daughter (PRINT participant's name) \_\_\_\_\_  
First Last

to participate in the event sponsored by \_\_\_\_\_ Parish. I hereby release and indemnify the Archdiocese of Chicago, \_\_\_\_\_ Parish for this event, its staff and volunteers; and the Catholic Bishop of Chicago, a Corporation Sole, from any and all liability arising from claims of any kind or nature whatsoever from my child's participation in the program. I understand that if my child violates any laws regarding possession of alcohol or drugs, or rules governing the event, I will be called and notified about situation and/or arrangements made to send my child home.

We will send an e-mail confirming your participation in this event to the address you provide below:

\_\_\_\_\_ e-mail address

\_\_\_\_\_ Parish may use photographs/videos  
Yes No of my child at this event for promotion in the bulletin/parish website/parish Facebook page.

\_\_\_\_\_ Student Signature

\_\_\_\_\_ Parent/Guardian Signature

\_\_\_\_\_ Date

### MEDICAL AUTHORIZATIONS

In the event that the undersigned cannot be reached, and in the judgment of the responsible adults or other appropriate staff members accompanying the group. If there is a necessity for immediate examination and/or treatment of my child. I hereby authorize any of the aforesaid personnel to obtain for my child such medical services as are deemed necessary.

**I GRANT PERMISSION** for the adult chaperons for this event to administer non-prescription drugs as needed for my teen (aspirin, ibuprofen, antacids, etc.) \_\_\_\_\_ YES \_\_\_\_\_ NO

**EMERGENCY CONTACT** (In event that parent(s)/guardians(s) cannot be reached.)

**NAME OF EMERGENCY CONTACT** \_\_\_\_\_

Relationship \_\_\_\_\_ Phone No. ( ) \_\_\_\_\_

**NAME OF PHYSICIAN** \_\_\_\_\_ Phone No. ( ) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

### INSURANCE INFORMATION

Policy in the Name of \_\_\_\_\_ Policy # \_\_\_\_\_

Insurance company \_\_\_\_\_ ID # \_\_\_\_\_

### HEALTH INFORMATION

Allergies: \_\_\_\_\_ Current Med \_\_\_\_\_

Other Comments \_\_\_\_\_

\_\_\_\_\_ High School

\_\_\_\_\_ Name of Youth Group Leader

**Return this completed form to** \_\_\_\_\_ **by** \_\_\_\_\_

**Questions? Contact** \_\_\_\_\_