

Retreat Registration Form

Date of Retreat February 18-20, 2011

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

Phone Number \_\_\_\_\_ email \_\_\_\_\_

Does this retreatant have a guardian? \_\_\_\_ If yes who is the guardian? \_\_\_\_\_

Religious Affiliation \_\_\_\_\_

Registration fee of \$35.00 is enclosed \_\_\_\_\_ I would like to apply for scholarship \_\_\_\_\_

In case of an emergency, who should be contacted if parent or guardian is unreachable?

\_\_\_\_\_

Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Would you like your name and phone number to be given to other persons from your area for the purpose of coordinating rides? Yes \_\_\_\_ No \_\_\_\_

Can this person sleep in a top bunk? Yes \_\_\_\_ No \_\_\_\_

Occasionally photographs taken of retreatants and helpers are published in the Good News, the diocesan newspaper and web site, or used in brochures describing the retreat program or other activities sponsored by Ministry with Persons with Disabilities.

Photos of this retreatant/volunteer may be used for the purposes described above. \_\_\_\_\_

Do not publish photos of the retreatant/volunteer \_\_\_\_\_

I hereby consent to the participation by (name) \_\_\_\_\_ on the Retreat, sponsored by the Diocese of Kalamazoo. I understand that the Retreat will take place at Camp Friedenswald and that my son,/daughter/ward will be under the supervision of program staff during this event.

I also give my permission for a qualified person to give medical attention to the above named person in the event of an emergency.

Special conditions: \_\_\_\_\_

\_\_\_\_\_

Medication (Please give name of medication, and for what purpose taken):

**LIST MEDICATION AND DOSE**

	Breakfast	Lunch	Dinner	Bed	Other
Friday					
Saturday					
Sunday					

Allergies?: \_\_\_\_\_

History of seizures?: \_\_\_\_\_

Are there any special bedtime routines, need for a night light or other accommodations that will make the retreat more comfortable? \_\_\_\_\_

Physician's Name \_\_\_\_\_

Physician's Phone \_\_\_\_\_

Insurance Company \_\_\_\_\_

Insurance Number or Group Number \_\_\_\_\_

\_\_\_\_\_  
Signature of parent/guardian/participant

\_\_\_\_\_  
Date

Return to  
Ministry with Persons with Disabilities Diocese of Kalamazoo  
215 North Westnedge Avenue Kalamazoo, MI 49007 (269) 349-7276  
asherzer@dioceseofkalamazoo fax 269-349-6440

**Over**