

Youth Code of Behavior  
IHM Life Teen Winter Retreat

# Search

1. You represent the Catholic Church. You are expected to project an image of Christian consideration, sensitivity and respect for other people and property around you.
2. Attendees should respect and obey the adult chaperones.
3. No one may leave the group without permission; in the unlikely event that a need to leave the retreat arises, consent of the Youth Minister is REQUIRED.
4. Any person caught in possession of alcoholic beverages, vapes, Juul or any illegal drug will be dismissed **IMMEDIATELY. Parents will be called at any hour to retrieve their child.**
5. Respect all YMCA Blue Ridge Assembly rules and stay out of off-limit areas.
6. **EVERYONE** is responsible for clean-up. Any damage will be the responsibility of the individual.
7. Any infraction of any rules set forth by the youth minister, adult chaperones, or camp staff could result in immediate dismissal from the retreat and/or ask not to return to Life Teen.

**I have read and understand the above rules. I agree to abide by them for the duration of the IHM Winter Retreat. I am aware that in failing to do so, I can be dismissed from the event and/or asked not to return to Life Teen**

Youth Participant's Name (Printed): \_\_\_\_\_

School and Grade: \_\_\_\_\_

Youth Participant's Signature: \_\_\_\_\_

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

Date: \_\_\_\_\_

Parent/Guardian Cell #: \_\_\_\_\_

Parent/Guardian Email: \_\_\_\_\_

T-Shirt Size: \_\_\_\_\_

Notes (anything we should know for the weekend, i.e. health or behavior):

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**DIOCESE OF CHARLOTTE, NC  
PARENTAL/LEGAL GUARDIAN PERMISSION FORM FOR FIELD TRIP  
PARTICIPATION**

Dear Parent or Legal Guardian:

Your son/daughter, guardianship is eligible to participate in a Diocesan-sponsored activity that requires personal transportation to locations away from your home site. This activity will take place under the guidance and supervision of adult chaperones. A brief description of the activity follows:

ACTIVITY: \_\_\_\_\_

DESIGNATED SUPERVISOR OF ACTIVITY: \_\_\_\_\_

\_\_\_\_\_  
If you would like your child to participate in this event, please complete, sign and return the following statement of consent and release of liability. As parent, or legal guardian, you remain fully responsible for any legal responsibility which may result from any personal actions taken by the named child. I hereby consent to participation by my child, \_\_\_\_\_, in the event described above. I understand that this event will take place away from parish grounds and that my child will be under the supervision of the designated supervisor on the stated dates. I further consent to the conditions stated above on participation in this event, including the method of transportation. I give my permission for my child, in case of an emergency, to be taken to a physician or hospital by either the supervisor in charge or by an adult chaperone. I understand that every effort will be made to contact me. If I cannot be reached, however, I hereby give permission to the physician selected by the supervisor in charge or adult chaperone(s) to hospitalize and secure proper treatment (including surgery) for my son/daughter. The cost of any necessary medical care or treatment for my son/daughter will be my expense.

Parent's or Legal Guardian's Signature Date: \_\_\_\_\_

Phone number where you can be reached in case of emergency: \_\_\_\_\_

Accident/Hospitalization Policy Name: \_\_\_\_\_

Policy Number: \_\_\_\_\_

\_\_\_\_\_  
Please complete return this entire form by: Friday November 23, 2018

# HEALTH HISTORY FORM

DATE \_\_\_\_\_  
CHILD'S NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_  
ADDRESS \_\_\_\_\_ PHONE (\_\_\_\_) \_\_\_\_\_  
PARENT'S NAME \_\_\_\_\_ WK NO (\_\_\_\_) \_\_\_\_\_  
EMERGENCY CONTACT \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_  
MEDICAL INSURANCE \_\_\_\_\_

POLICY # \_\_\_\_\_

## A. ILLNESSES AND INJURIES (CHECK THOSE THAT APPLY)

\_\_\_\_ ASTHMA \_\_\_\_ DIABETES \_\_\_\_ EPILEPSY \_\_\_\_ KIDNEY DISEASE  
\_\_\_\_ CONVULSIONS/SEIZURES \_\_\_\_ EAR INFECTION \_\_\_\_ HEART DISEASE  
DATE OF LAST HEALTH EXAM \_\_\_\_\_ ANY MEDICAL PROBLEMS NOTED?  
\_\_\_\_\_

IF YES, PLEASE EXPLAIN

\_\_\_\_\_  
SINCE CHILD'S LAST EXAM HAS HE/SHE HAD:  
A SERIOUS ILLNESS \_\_\_\_\_ WHAT? \_\_\_\_\_  
AN ILLNESS LASTING LONGER THAN A WEEK? \_\_\_\_\_  
AN OPERATION OR FRACTURE? \_\_\_\_\_  
TREATMENT IN A HOSPITAL OR EMERGENCY ROOM? \_\_\_\_\_  
RESTRICTIONS FROM PHYSICAL ACTIVITY \_\_\_\_\_  
MEDICATION TO BE TAKEN ON A REGULAR  
BASIS \_\_\_\_\_

## B. ALLERGIES (CHECK THOSE THAT APPLY)

\_\_\_\_ ANIMALS \_\_\_\_ MEDICINES \_\_\_\_ INSECT STINGS \_\_\_\_ FOOD  
\_\_\_\_ PLANTS \_\_\_\_ HAYFEVER \_\_\_\_ POLLEN \_\_\_\_ OTHER  
PLEASE SPECIFY IF ANY ARE CHECKED  
\_\_\_\_\_

## C. IMMUNIZATIONS

IMMUNIZATION YEAR PRIMARY SERIES COMPLETED YEAR OF LAST BOOSTER  
DPT \_\_\_\_\_  
MEASLES \_\_\_\_\_  
MUMPS \_\_\_\_\_  
ORAL POLIO \_\_\_\_\_  
RUBELLA \_\_\_\_\_  
TB TINE \_\_\_\_\_  
CHICKEN POX \_\_\_\_\_  
HIB HEPATITIS \_\_\_\_\_

## D. OTHER HEALTH CONDITIONS:

## E. PERMISSION TO SEEK MEDICAL HELP

IF I CANNOT BE REACHED IN CASE OF EMERGENCY, THE BEARER OF THIS FORM IS AUTHORIZED TO ACT ON MY BEHALF TO SEEK MEDICAL TREATMENT AS THEY DEEM NECESSARY FOR MY CHILD \_\_\_\_\_

SIGNATURE OF PARENT/GUARDIAN \_\_\_\_\_ DATE \_\_\_\_\_