

ADULT PERMISSION SLIP
HOLY CROSS CONFIRMATION RETREAT—SINGING HILLS CONFERENCE CENTER
FOR EACH ADULT ATTENDING

Last Name: _____ First Name: _____

Date of Birth: ____/____/____ eMail: _____

Address: _____

City: _____ State: _____ Zip: _____ Home Phone: _____

Cell Phone: _____ Pager: _____

Place of Employment: _____ Phone: _____

Emergency Contact Name: _____

Phone: _____ Cell/Pager: _____

Emergency Contact Name: _____

Phone: _____ Cell/Pager: _____

Known Allergies to Food or Medication: _____

Previous Serious Medical Conditions: _____

Primary Care Physician: _____ Phone: _____

Health Insurance Company: _____

Policy Number: _____

I hereby grant permission to Holy Cross Church to secure such medical care as I may require, for the period from (date) _____ (time of departure) _____ to (date) _____ (time of arrival) _____ including examination, treatment, and immunization. This permission is conditional upon the understanding that in the event of serious illness or the need for an operation and/or major surgery, Holy Cross Church will use all reasonable efforts to contact the emergency contacts I have provided. Failure in such efforts, however, should not prevent Holy Cross Church from providing such treatment as may be necessary for my best interest.

Signature

Date

**HOLY CROSS PERMISSION SLIP—FOR EACH CHILD ATTENDING
CONFIRMATION RETREAT—SINGING HILLS CONFERENCE CENTER**

Child's Last Name: _____ First Name: _____

Date of Birth: ____/____/____ Height: _____ Weight: _____

Family Address: _____

City: _____ State: _____ Zip: _____ Home Phone: _____

Father's Name: _____ Employer: _____

Cell Phone/Pager: _____ Work Phone: _____

Mother's Name: _____ Employer: _____

Cell Phone/Pager: _____ Work Phone: _____

Additional
Emergency Contact _____ Relationship: _____

Phone: _____ Cell/Pager: _____

Allergies to
Medications or
Foods: _____

Medications
Presently Taken _____

Parental Permission
for Medications _____ (Signature REQUIRED for any prescrip-
tion and over the counter medications)

Date of Last
Tetanus Booster: ____/____/____ Previous Surgery: _____

Previous Serious
Medical Conditions _____

Family Doctor: _____ Telephone: _____

Surgeon: _____ Telephone: _____

Health Insurance
Company: _____ Policy #: _____

We/I hereby grant permission to Holy Cross Church to secure such medical care as
_____ [child's name] may require, for the period
from [date] _____ [time of departure] _____
to [date] _____ [time of arrival] _____
including examination, treatment, and immunization. This permission is conditional upon the
understanding that in the event of serious illness or the need for an operation and/or major
surgery, Holy Cross Church will use all reasonable efforts to contact the emergency contacts
that have been provided. Failure in such efforts, however, should not prevent Holy Cross
Church from providing such treatment as may be necessary for
_____ [child's name] best interest.

Signature of Parent or Legal Guardian

Date