

J2A Retreat at Camp DeWolfe

Outline of Events

Saturday

10:00	Arrival & Check-in
10:30	Welcome & Opening Prayer
10:45	Morning Activities
12 noon	Lunch
1:00	Challenge Course Activities
5:00	Dinner
6:00	Evening Activities
10:00	Compline
11:00	Lights Out

Sunday

7:30	Morning Prayer
8:00	Breakfast
9:00	Morning Activities
11:15	Eucharist
12 noon	Lunch
1:00	Retreat Wrap-up & Concluding Prayer
1:30	Pick-up

Please return with payment by Oct 18th

Cathedral of the Incarnation
50 Cathedral Avenue
Garden City, NY 11530
(516) 746-2955

PARENTAL PERMISSION AND RELEASE FORM

Minor's Name: _____

Date of Birth: _____ Soc. Sec. #: ___xxx-xx-_____

Address: _____

City/State/Zip _____

Day Phone: _____ Evening Phone: _____

Event/Trip: **J2A Retreat to Camp DeWolfe**

Date: **October 18th – 19th, 2014**

Time: **Arrive at Camp DeWolfe 10:00am Saturday, October 24th.
Pick-up from DeWolfe 1:30pm on Sunday, October 25th.**

Cost: **\$85.00/person**

Release of the Cathedral of the Incarnation, Garden City, NY

_____ (Parent's name) shall indemnify, hold free and harmless, assume liability for and defend the Cathedral of the Incarnation, its agents, servants, employees, officers and directors from any and all costs and expenses including but not limited to attorney's fees, reasonable investigative and discovery costs, court costs, and all other sums which the Cathedral of the Incarnation, assertion of liability, or any claim or action founded thereon, arising or alleged to have arisen out of _____ (minor's name) use of real or personal property belonging to the Cathedral of the Incarnation, its agents, servants, employees, officers and directors, or by action or omission by _____ (minor's name).

Authorization to Consent to Treatment of a Minor:

- (1) (We), the undersigned, parent(s) of _____, a minor, do hereby authorize youth/music ministry leaders of the Cathedral of the Incarnation as agents for the undersigned to consent to any x-ray, examination, anesthetic, medical or surgical diagnosis or treatment, and hospital care which is deemed advisable by, and is to be rendered under the general or specific supervision of any physician and surgeon licensed under the provision of the Medical Practice Act, whether such diagnosis or treatment is rendered at the office of the said physician or at a hospital.
- (2) It is understood that this authorization is given in advance of any diagnosis, treatment or hospital care being required, but is given to provide authority and power on the part of our aforesaid agent(s) to give specific consent to any such diagnosis, treatment or hospital care which the aforementioned physician in the exercise of his/her best judgment may be advisable.

Parent/Guardian Signature: _____ Date: _____

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Journey 2 Adulthood DeWolfe Retreat
October 24th – 25th, 2015

My son/daughter _____ has the following dietary, physical and/or allergic concerns:

Medicine Release

My son/daughter has permission to self administer the following prescriptions in accordance with the original pharmacy bottle label.

_____	_____
_____	_____
_____	_____
_____	_____

My son/daughter has my permission to self administer the following OTC – Over the Counter products:

_____	_____
_____	_____
_____	_____

Parent/Guardian Date: _____

Emergency Contact phone # _____