8th grade RETREAT *at Trinity!*

March 2-3, 2018

6:30 p.m. Friday – 5:00 p.m. Saturday

EAT ***before you come to the retreat!***

BRING: *sleeping bag, pillow, personal items, and a change of clothes.*

If you have a **CONFLICT:** contact Linda a.s.a.p. at 651-261-7880 / linda@trinitylindstrom.org

REMEMBER: This is a **REQUIRED** *retreat: we will have* ***3 lessons during the retreat.***

We will serve at ***FEED MY STARVING CHILDREN*** Saturday afternoon.

Please return this slip by ***Wednesday, February 28***

PERMISSION / CONSENT FORM:

I hereby give my consent to have my minor child, ____ participate in the **8th grade Confirmation Retreat** at Trinity and FEED MY STARVING CHILDREN in Coon Rapids **on March 2-3, 2018** with Trinity Lutheran Church, Lindstrom, MN.

I recognize that there are risks involved in participating in this activity with Trinity Lutheran Church and hereby assume all risk of injury, harm, or damage to my minor child as they participate in this activity. I hereby release and agree to hold harmless Trinity Lutheran Church and its employees, organizers, and any volunteers assisting in the program, from any and all liability and claims arising out of my child's participation in programs and related activities. I hereby release Trinity Lutheran Church, its staff and sponsors, from responsibility and liability for any injury or illness that my child may sustain during the event.

In case of emergency, where I cannot be reached, I hereby authorize Trinity Lutheran Church to administer necessary first aid or seek emergency medical attention for my child. I hereby authorize an adult leader of this event, as agent for me, to consent to any x-ray examination; medical, dental or surgical diagnosis; treatment; and/or hospital care advised and supervised by a physician, surgeon, or dentist (as appropriate) licensed to practice under the laws of the state where the services are rendered, either at the doctor's office or in any hospital. I expect to be contacted as soon as possible. I understand that I am responsible for the health care decisions of my minor child and agree that my insurance plan is the primary plan to pay for the medical, dental, or hospital care or treatment that is given to my minor child.

I give my permission for my child to be photographed/videotaped. I understand that the images may be displayed in church publications, church building, website and/or social media. I understand that as a precaution, my child's names will NOT be published or linked with photographs.

____ **Date**_________________________

Signature of Parent/Guardian

EMERGENCY INFORMATION: In case of emergency, please contact (when parent/guardian cannot be reached):

Name____

Phone(s) ____

MEDICAL INFORMATION:

DOCTOR __________________________________ Phone_______________ or

CIRCLE ONE: **C. L. Clinic 651-257-8400 ✦ Fairview-Wyoming 651-982-7000 ✦ St. Croix Clinic 1-800-642-1336**

Please list any allergies____

Medications being taken____

Medical/dietary needs____

Physical handicaps or limitations ____

Medical insurance company ___________________________Policy#______________ Group # ________________

Parents:

Would you be willing to help with the **WHOLE** retreat? Yes ____ No ____

Would you be willing to **DRIVE** Friday? Yes ___ No___

Saturday? Yes___ No___

Would you be willing to help:

Fri. from 6:30 – 11:00 p.m.	Yes ____	No ____
Fri. from 10:00 p.m. – 9:00 a.m.?	Yes ____	No ____
Sat. from 9:00 – 1:00 p.m.	Yes ____	No ____
Sat. from noon – 5:00 p.m.	Yes ____	No ____

We need 6-8 adults to help and 4-5 drivers!