DIOCESE OF
FORT WAYNE-SOUTH BEND

"COME & SEE"
MEN'S DISCERNMENT RETREAT

Friday, July 15th, 2022
9:00 a.m. to 5:00 p.m.
Sacred Heart Parish, 125 N. Harrison, Warsaw, IN

Name: _____ Age: _____

Home phone: _____Cell phone: _____

Home address: _____

City and Zip: _____ Parish I attend: _____

Email Address: _____

Attendee: I request to participate in the Come & See Men's Discernment Retreat. I understand that by requesting to go, I am promising to cooperate with the Retreat Team and the Vocation Office of the Diocese of Fort Wayne-South Bend. I understand that the intention of the retreat is to help form community and to bring me closer to God. I promise to follow instructions and be open. I also realize that I may not bring or use tobacco products, illegal drugs, or alcohol.

Participant Signature: _____ **Date:**_____

Parents: I, _____

grant permission for my child, _____
to participate in the Come & See Men's Discernment Retreat sponsored by the Vocations Office of the Diocese of Fort Wayne-South Bend on July 15, 2022. This activity will take place under the guidance and direction of seminarians and volunteers from the Vocations Office The individual in charge is Fr. Andrew Budzinski. The retreat will take place at Sacred Heart Parish, Warsaw, IN.

Parent Signature: _____ **Date:**_____
(if participant is a minor)

Parent e-mail address: _____

Participant Medical Authorization Form

As parent and/or legal guardian, I remain legally responsible for any personal actions taken by the above named minor ("participant"). I agree on behalf of myself, my child named herein, or our heirs, successors, and assigns, to hold harmless and defend Sacred Heart Parish, Warsaw, its officers, directors, employees and agents, and the Diocese of Fort Wayne-South Bend, its employees and agents, chaperones, or representatives associated with the event, from any claim arising from or in connection with my child attending the event or in connection with any illness or injury (including death) or cost of medical treatment in connection therewith, and I agree to compensate the parish, its officers, directors and agents, and the Diocese of Fort Wayne-South Bend, its employees and agents and chaperones, or representatives associated with the event for reasonable attorney's fees and expenses which may incur in any action brought against them as a result of such injury or damage, unless such claim arises from the negligence of the parish/diocese.

Signature: _____ Date: _____

Medical Matters: I hereby warrant that to the best of my knowledge, my child is in good health, and I assume all responsibility for the health of my child. ***Please read the statements below pertaining to medical matters; sign only those that are applicable.***

Emergency Medical Treatment: In the event of an emergency, I hereby give permission to transport my child to a hospital for emergency medical or surgical treatment. I wish to be advised prior to any further treatment by the hospital or doctor. In the event of an emergency, if you are unable to reach me at the above numbers, contact:

Name and relationship:_____ Phone: _____

Family Doctor:_____ Phone:_____

Family Health Plan Carrier: _____ Policy # _____

Signature:_____ Date:_____

Other Medical Treatment: In the event it comes to the attention of the parish its officers, directors and agents, and the Diocese of Fort Wayne-South Bend, chaperones or representatives associated with the activity, that my child becomes ill with symptoms such as headache, vomiting, sore throat, fever, diarrhea, I want to be called collect (with phone charges reversed to myself).

Signature:_____ Date:_____

Medications: My child is taking medication at present. My child will bring all such medications necessary, and such medications will be well-labeled. Names of medications and concise directions for seeing that the child takes such medications, including dosage and frequency of dosage, are as follows:

_____

_____

Signature:_____ Date:_____

Please sign <u>one</u> of the two below:

No medication of any type, whether prescription or non-prescription, may be administered to my child unless the situation is life-threatening and emergency treatment is required.

Signature:_____ Date:_____

I hereby grant permission for non-prescription medication (i.e. non-asprin products such as acetaminophen or ibuprofen, throat lozenges, cough syrup) to be given to my child, if deemed appropriate.

Signature:_____ Date:_____

Specific Medical Information: The diocese will take reasonable care to see that the following information will be held in confidence.

Allergic reactions (medications, foods, plants, insects, etc.): _____

OVER PLEASE

Immunizations: Date of last tetanus/diphtheria immunization: _____
Does child have a medically prescribed diet? _____
Any physical limitations? _____
Is child subject to chronic homesickness, emotional reactions to new situations, sleepwalking, bedwetting, fainting?
_____
Has child recently been exposed to contagious disease or conditions, such as mumps, measles, chicken pox, etc.? If so, list date and disease or condition: _____
You should be aware of these special medical conditions of my child: _____

Please scan, photograph or email the completed form to:
Vocations Office
Cbonahoom-nix@diocesefwsb.org
260-422-4611