CATHOLIC DIOCESE OF KALAMAZOO

2026 CONFIRMATION RETREAT REGISTRATION

In consideration of my child being allowed to participate in this Confirmation Retreat, I agree to indemnify and hold harmless St. Monica Catholic Church, the Diocese of Kalamazoo and any and all affiliated organizations, their employees, agents, representatives, including volunteer and other drivers, from any and all claims, negligence, arising from or relating to my child's participation in this sport. This indemnification does not apply to claims for intentional misconduct or gross negligence.

Please select **ONE** of the following:

☐ With my signature below, I hereby grant permission to Diocese of Kalamazoo and its parishes to publish my child's name, photo, or video image in connection with a display, feature story or other publication as deemed appropriate by the Diocese of Kalamazoo and its parishes.

☐ **I do not give permission** for the publication of my child's name, photo, or video image in connection with a display, feature story or other publication as deemed appropriate by the Diocese of Kalamazoo or its parishes.

As a parent/guardian, I do hereby authorize the treatment by a qualified and licensed physician of any condition which, in the opinion of the physician, is deemed necessary and appropriate. This authority is granted only after a reasonable effort has been made to reach me.

Name of Minor: _____ Age: _____

Minor's Date of Birth: _____ Name of Parent: _____

Primary Phone _____ Secondary Phone: _____

Reason for which release is intended: 2026 Confirmation Retreat held at St. Monica Catholic Church.

Address of Minor: _____ City: _____

Emergency Contact: _____ Relationship to Minor: _____

Phone(s): _____ _____

Family Physician: _____ Phone: _____

Physician Address: _____ City: _____

List allergies, medications, contacts, or other pertinent comments (attach second sheet if necessary): _____

_____ _____

HEALTH INSURANCE DATA:

Company: _____ Policy: _____

Group: _____ Contract: _____

I further authorize the person who presents the minor to sign the Acknowledgment of Receipt of Notice Privacy Rights that may be presented by the physician or health care facility. By entering into and/or signing this document, the signatory/signatories agree to conduct its/their dealings via electronic means. The signatory agrees that allowing dealings via electronic means will facilitate these dealings. The signatory has the option to opt to sign things in a paper format. **I fully understand and agree to the above terms and sign this form knowingly, willingly and freely.**

This authorization is completed and signed of my own free will with the sole purpose of authorizing medical treatment deemed necessary and appropriate by the treating physician.

Date: _____ Signed: _____

(Parent or Guardian)

Home address: _____ City, State, Zip: _____