APPLICATION FOR THE JOURNEY RETREAT

NAME

ADDRESS CITY

STATE ZIP

PHONE (HOME) (MOBILE)

EMAIL ADDRESS

DATE OF BIRTH AGE GRADE

PARISH

DATE OF WEEKEND YOU ARE APPLYING:

PARENT / GUARDIAN INFO

(DAD NAME) (MOM NAME)

(DAD PHONE) (MOM PHONE)

(DAD EMAIL) (MOM EMAIL)

HAVE YOU EVER BEEN ON A WEEKEND RETREAT ?

IF SO , CAN YOU NAME THEM ?

SCHOOL ACTIVITIES ?

ADDITIONAL INTERESTS ? HOBBIES ?

JOURNEY SPONSOR ? (WHO INVITED YOU)

HAS YOUR SPONSOR ANSWERED ANY QUESTIONS YOU HAVE ABOUT THE WEEKEND ?

HAS YOUR SPONSOR INFORMED YOU THAT THE WEEKEND BEGINS ON THURS AT 7PM AND ENDS SUNDAY AFTER 5PM ?

(PLEASE USE THE BACK OF THIS PAPER TO ANSWER THE FOLLOWING 2 QUESTIONS)

1) WHY WOULD YOU LIKE TO ATTEND A JOURNEY WEEKEND ?
2) WHAT DO YOU HOPE TO GAIN BY ATTENDING A JOURNEY WEEKEND ?

PLEASE SUBMIT THIS APPLICATION ALONG WITH A MEDICAL FORM AND CONSENT FORM ALONG WITH YOUR PAYMENT OF $200 TO: (CHECKS MAKE PAYABLE TO : THE JOURNEY RETREAT PROGRAM)

ST KATERI TEKAKWITHA PARISH

ATT: JOURNEY RETREAT

2216 ROSA ROAD , SCHENECTADY , NY 12309

MEDICAL INFORMATION:

Allergies _____

Required Medications _____

(please include dosages, frequency, etc.)

Special Medical Conditions_____

_____

Special Dietary Considerations or Restrictions:

_____

Date of Last Tetanus Booster _____

INSURANCE INFORMATION:

Insurance/Carrier Name _____

Policy Number/Group Number _____

Name of Primary person on Insurance _____

IN CASE OF EMERGENCY, CONTACT ME AT:

Home Phone_____ Work Phone _____

Cell Phone or Pager _____

IN CASE OF EMERGENCY AND I CANNOT BE REACHED, PLEASE CONTACT:

Name_____ Phone_____

Name_____ Phone_____

RELEASE AND CONSENT FORM for THE JOURNEY RETREAT

PARENT (please type or print)

I, _____, (Parent [ ] Legal Guardian [ ]) undersigned, give

my permission for my son/daughter _____ to attend the Journey Retreat Weekend

to be held at the Dominican Retreat Center in Niskayuna, NY from **Thursday evening** **to**

Sunday evening and if needed to be evaluated, diagnosed, treated, and/or medicated in

accordance with standard medical practice by licensed medical personnel.

I relieve the parish of _____ and the Diocese of Albany, The Dominican Retreat Center and the Journey Retreat Program of all responsibility and consequences which may arise as a result of this treatment.

I will not hold the above parish, nor the Diocese of Albany, The Dominican Retreat Center, chaperones, Spiritual Directors or representatives associated with the retreat responsible in the event of injury. Further, I agree to accept any and all financial responsibility as a result of scheduling such treatment.

My child agrees to abide by all rules and regulations decided upon by the above parish, the Diocese of Albany, The Dominican Retreat Center and the Journey Retreat Program. I understand that neither the above parish nor the Journey Retreat Program will be held liable if my child fails to cooperate with said regulations and that any infraction of the rules may result in immediate dismissal from the Journey Retreat Weekend. I further understand that I will be responsible for any costs of other requirement for immediate transportation home.

YOUTH

As a member of the above parish, I _____, understand and agree to the rules and regulations as determined by the Diocese of Albany, The Dominican Retreat Center, and the Journey Retreat Program. I also understand and agree that I will notify my parents/guardians at the time of any infractions requiring my dismissal from the Retreat weekend and that I will be sent home at my own and/or my parent's/guardian's expense.

_____ _____

Signature of Parent/Guardian Date

_____ _____

Signature of Youth Participant Date