

Sacred Heart Church Parish Office 1301 Cooper Ave, Turlock, CA
(209)634-8578 email: sacredheartturlock@gmail.com Website: www.shparish.net

Office of Faith Formation English Confirmation Youth Retreat (Year 2)

Retreat Fee: \$40.00 (Make checks payable to Sacred Heart Confirmation Retreat-PLEASE pay at Parish Office 1301 Cooper Ave) Office hours 9:00 AM to 5:00 PM for a VENMO payment call the parish office (209)634-8578 and email the form to sacredheartturlock@gmail.com **PAYMENT Due: July 18th, 2025**

Date of Retreat: August 2, 2025 (School Grades 7th-High School) Beginning Time: **8am Mass** in the Church **(Parent or Sponsor expected to attend mass with their child(ren))**. After mass, PLEASE sign your child in, AT the Parish Gym. The retreat will end at **4:30pm**. (Lunch will be provided for candidates)

Location: 8am Mass Sacred Heart Church 1200 Lyons Ave. PLEASE Sign-In (after mass) AT the Sacred Heart Parish Gym, corner of Rose Ave./Cooper St. Turlock, CA

Candidates Needs to Bring: Bible and Cheerful outlook!

Retreat Coordinator: Mrs. Becky Beltran & Confirmation Team

**Parish office: 1301 Cooper St. Turlock
(209) 602-5889 Becky Beltran**

**NO ONSITE
REGISTRATION**

Please Keep This Portion for Your Information

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Year 2 Confirmation Retreat Participation/Medical Release Form

Name of Student: _____ **Date of Retreat:** August 2nd **School Grade:** _____

Destination: Confirmation Year Two Retreat-Sacred Heart Church Gym-600 Rose Turlock, CA 95380

I, the undersigned parent/guardian of the above-named student, give my permission for his/her participation in the above-named retreat. I hereby release and save harmless the school/parish and any and all of its employees from any and all liability for harm arising to my child and for any loss of property as a result of this trip.

MEDICAL PERMISSION: I, the undersigned parent/guardian of the above-named student, do hereby authorize and consent to any x-ray examination, anesthetic, medical or surgical diagnosis rendered under the provision of the Medical Practice Act, or a dentist licensed under the provisions of the Dental Practice Act and on the staff of any acute general hospital holding a current license to operate a hospital from the State of California Department of Public Health. It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required, but is given to provide authority and power to render care which the physician in the exercise of his/her best judgment may deem advisable. It is understood that effort shall be made to contact the undersigned prior to rendering treatment to the patient, but that any of the above treatment will not be withheld if the undersigned cannot be reached. I will not hold Sacred Heart School/Parish, its officers, or agents, liable for medical aid rendered. This authorization is given pursuant to Section 25.8 of the California Civil Code and remains effective only for the event and date listed above.

Full Name of Child _____ Date of Birth _____

Home Address _____ Home Telephone _____

Name of Parent/Guardian _____ Parent/Guardian Work Phone _____

If Unable to Locate Parent/Guardian, Contact _____ Relationship _____ Phone _____

Physician's Full Name _____ Phone _____ Insurance Company _____

Is your child currently taking any medications? No ____ Yes ____ Kind _____ Dosage _____

Drug Allergies? _____ **Food Allergies?** _____ **Other**

Concerns or Limitations? _____

Parent/Guardian Signature _____ **Date** _____

Candidate Signature _____ **Date** _____

**BE SURE YOU HAVE
DETACHED THE UPPER
PORTION, IT IS FOR YOUR
INFORMATION, DATE & TIME**