

**Sacred Heart Church, Turlock**  
**First Eucharist Child and Parent (or Sponsor) Retreat**  
**Participation/Medical Release Form**

**Retreat Fee: \$20.00** (Make checks payable to Sacred Heart EFF- Please PAY at Parish Office 1301 Cooper Ave) Office hours 9:00 a.m. to 5:00 p.m. for **VENMO** see the QR code for questions call the parish office, 209-634-8578  
**PAYMENT DUE: March 12<sup>th</sup>, 2026.**

**Date of Retreat: Saturday, March 21, 2026. Beginning Time: 9:00 am to 12:30 pm at the Parish School Gym.**  
**The retreat will end at 12:30pm.**

**Location: Sacred Heart School Gym at the corner of Rose/Cooper Sts. Turlock, CA 95380**

**Retreat Coordinators: Mrs. Becky Beltran & Eucharist Catechist Team**

**Parish Office: 1301 Cooper St. Turlock, Ca**

**NO ONSITE  
REGISTRATIONS**

**(209) 602-5889 Becky Beltran**



**venmo**

**Please Keep This Portion for Your Information**

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**First Eucharist Child and Parent (or Sponsor) Retreat /Medical Release Form**

Name of Student: \_\_\_\_\_ **Date of Retreat: March 21, 2026**

**Destination: First Eucharist Child/Parent (or Sponsor) Retreat- Sacred Heart Church School Gym 600 Rose St. 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**

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