Sacred Heart Church (Year 1) Youth Confirmation Retreat C1
Retreat Master: Tanya Velazquez & CCHS Senior Ministry Team
Retreat Theme: "Advent-Preparing Our Hearts for Christ"

Retreat Fee: $25.00 (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: December 4th, 2024 Date of Retreat: December 7th, 2024 (School Grades 6th-9th) Beginning Time: 8am Mass in the Church (Parent expected to attend mass with their child(ren). After mass, PLEASE sign your child in, AT the Parish Gym. The retreat will end at 1:30pm. (Lunch will 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/Cooper Sts. Turlock, CA 95380

Candidates Needs to Bring: Bible and Cheerful outlook!

NO ONSITE REGISTRATIONS

Retreat Coordinators: Mrs. Becky Beltran & Confirmation Team

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

Please Keep This Portion for Your Information

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Year 1 Confirmation Retreat Participation/Medical Release Form

Name of Student: _____ **Date of Retreat**: December 7th **(Grades 6th-9th)** ____
Destination: Confirmation Year One 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 underostood 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