



Warriors at Heart

Be on your guard, stand firm in the faith, be courageous, be strong. 1Cor 16:13

High School - Guy's Retreat

Hosted by *Ignite* in union with St Pius X, St Stephens and St Mary's

January 6-7, 2012

Friday 5:00pm until Saturday after 5:00 Mass

Cost is \$20 - For additional registration information;

Call or text Rod Wood at 616-318-8099 or email rodnejwood@gmail.com

Call Erin Duba at 538-2600 x137 or email eduba@spxcatholic.org

Call Kaitlin Roberts at 616-243-8998 x 205 or kaitlinroberts@ststephenparish.com

Call Pam LaPerna at 616-681-9701 x 203 or plaperna@smvchurch.org

St Sebastian Catholic Church Youth Ministry

Warriors at Heart

RETREAT REGISTRATION FORM

STUDENT INFORMATION

Name _____	Phone # _____
Email Address _____	Grade _____
Mailing Address _____	
City _____	State _____ Zip _____
Two Questions you have about God, your faith or the Catholic Church, that you would like answered on this retreat.	
1. _____	
2. _____	
Registration Deadline DECEMBER 31, 2011	
Return \$20 payment and form to; St Sebastian Catholic Church Youth Ministry Office located at	
9508 Wilson Avenue SW—Byron Center 49315	

PARENT CONSENT

As parent or legal guardian, I agree to remain fully responsible for the actions and conduct of my child, and I hereby consent to participation of my child, _____, in the **Warriors at Heart Retreat**. I understand that this event will take place at St Sebastian Parish Hall. I further consent to conditions stated above on participation for this event. In consideration of my child being allowed to participate in this event, I agree to waive and release, and indemnify and hold harmless St Sebastian Catholic Church, any and all affiliated organizations, their employees, agents, representatives, and volunteers, from any and all claims I or my child may have, excluding claims for intentional misconduct or gross negligence arising from or relating to my child's participation in this event. I authorize St Sebastian Catholic Church to obtain necessary medical treatment for my child in case of illness, injury, or accident.

I certify that I am the (check one) ___ custodial parent or ___ legal guardian of the minor child named above and I agree to the terms stated above terms for myself and minor child.

_____ Printed Name of parent or legal guardian	_____ Signature of parent or legal guardian
_____ Date	_____ Emergency Contact #

Please sign the medical release form on the reverse side.

MEDICAL TREATMENT RELEASE FORM

To Whom It May Concern:

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 child: _____ Relationship to you: _____

Reason for which release is intended: _____

Address of Minor: _____

Emergency Phone(s): _____

Family Physician: _____ Phone: _____

Physician's Address: _____

List allergies, medication, contact, or other pertinent comments:
