Lumberjack Awakening Retreat #23

Registration Form
March 3-5, 2018

Name *(Last, First)*		**Year in School:**	Fr So Jr Sr Grad
Phone:		Gender	M F
Email:	T-shirt size:		

ALLERGIES	
Food: (also, Vegan, etc)	
Environment:	
Medications and/or other:	

MEDICATIONS (if any)

EMERGENCY CONTACT INFORMATION	
Mother's Name:	
Address:	
Phone Number:	
Email:	
Father's Name:	
Address:	
Phone Number:	
Email:	

***The cost for participants is $65. Cash and checks are acceptable forms of payment. Checks can be made out to the Newman Center. If a scholarship is needed, please talk to Angela in person at the Newman Center, or call 928-779-2903.**

People of all faiths are welcome to attend this retreat. The retreat involves Catholic prayer and teaching. If you are not Catholic, check this box to receive more information about what will be happening on the retreat: ☐

[For Office Use] Staff: Yes / No Paid:_______________ Signed:_______________

Log: ______________________________ Contact:________

______________________________ In hand:________

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Consent/Release Form

March 3-5, 2018

Participant's Name: ________________________________Birthdate:____/____/____

Permanent Address:____

City ______________________________ State______________ Zip____________

I request to be permitted to participate in the Lumberjack Awakening Retreat from March 3-5, 2018, sponsored by Holy Trinity Catholic Newman Center.

I understand that reasonable precautions will be taken to safeguard the health and well being of the participants in this event and that I will be notified as soon as possible in the event of an emergency.

In the event of sickness or accident, I will not hold the Diocese of Phoenix, Holy Trinity Catholic Newman Center, San Francisco de Asis Parish, any of the leaders, or Happy Jack Lodge responsible. In the case of sickness or an accident, I authorize and consent to any X-ray, examination, anesthetic, medical, dental, or surgical diagnosis or treatment under the general or specific supervision, and on the advice of any physician, dentist or surgeon licensed to practice in the State of Arizona or any other state. I further understand and agree that any such medical, dental, or hospital expenses incurred shall be at my expense.

I agree to abide by all the rules and regulations stated at the event, those written and those stated verbally.

Participant's Signature _________________________________Date_______________

Insurance Company Name___________________ Insured Name ___________________

Insurance Policy #______________________

Physician's Name:_____________________ Physician's Phone #___________________

Emergency Person (other than parent): ___________________Phone:________________

Please note any other health or allergy conditions which would affect your participation or which should be given to an attending physician, dentist or surgeon: