

**Our Mother of Good Counsel Parish  
Parental Authorization Form**

Student: \_\_\_\_\_ Age: \_\_\_\_\_  
Parent(s): \_\_\_\_\_  
Address: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Emergency Phone: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_

I hereby grant permission for my child to take part in:

**Event: OUR MOTHER OF GOOD COUNSEL CONFIRMATION RETREAT**

**Destination: HOMER JUNIOR HIGH SCHOOL CAFETERIA 15711 S. BELL ROAD**

**Designated Supervisor: MRS. JANET LITTERIO-- RE COORDINATOR**

**Date & Time: SUNDAY, JANUARY 22, 2012--REPORT TO HJH CAFETERIA -12:45-12:50pm**

**Pick Up Time/Location: PICK UP STUDENTS AT HJH @6PM**

**Method of Transportation: PARENT'S CARS**

**Student Cost: N/A**

I hereby give permission for my child \_\_\_\_\_  
to participate in the **OUR MOTHER OF GOOD COUNSEL CONFIRMATION RETREAT.**

I hereby release and indemnify Our Mother of Good Counsel Parish, Homer Glen, IL; it's staff, volunteers, and the Joliet Diocese, from any liability arising from claims of any kind or nature whatsoever from my child's taking part in this event.

**Given the privilege to go on this trip, my child understands, recognizes, and will successfully execute all that is expected of her/him.**

**MEDICAL PERMISSION FORM:**

I grant the permission for the administration of first aid to \_\_\_\_\_

By the people in charge of: **OUR MOTHER OF GOOD COUNSEL CONFIRMATION RETREAT**  
as their judgment deems advisable, and to make the necessary referrals to qualified physicians for treatment of illnesses or accident and prior to any major surgery, except when delay in such communication would endanger life.

In case of medical emergency, I understand that every effort will be made to contact parents/guardian of the participant.

In the event I cannot be reached, I hereby give permission to the physician selected by the adult staff to hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery, if deemed necessary for my child.

**Please list any allergies of which we need to be aware, and also please indicate if your child is on any medication. Please enclose a note listing the medications and instructions.**

**Allergies:** \_\_\_\_\_

**Signature of Parent/Guardian:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Name of Authorized Physician:** \_\_\_\_\_

**Physician's Phone:** \_\_\_\_\_

**INSURANCE INFORMATION:**

**Policy in the name of:** \_\_\_\_\_

**Insurance Company:** \_\_\_\_\_

**Policy #:** \_\_\_\_\_ **Identification #:** \_\_\_\_\_

**PLEASE RETURN COMPLETED PERMISSION FORM NO LATER THAN:  
DECEMBER 14, 2011**