

# Christmas Traditions!

A retreat to reflect on the rich Christmas traditions we have through the Catholic Church, as well as other traditions we hold in our families.

**Thursday, December 29**

**9AM-3PM**

**St. Joseph Parish Center**

**\$5 plus money for lunch**

(we will go to Sal's Pizza/Jimmy John's – right outside our doors ☺)



Please turn your permission form and \$\$ into IPRF by Tuesday,  
December 27. Friends are welcome!

Any questions, please contact Celia at  
738-7413 or [iprf@inter-parish.org](mailto:iprf@inter-parish.org)

**Inter-Parish Religious Formation (IPRF) Waiver /Permission Form**

Please allow my child, \_\_\_\_\_ to attend \_\_Christmas Retreat\_(event) at \_\_St. Joseph Parish \_\_ (place) on \_\_12/27/11\_\_ (date).

.Transportation will be provided by \_\_N/A\_\_. In consideration of IPRF organizing this event, the parent / legal guardian of the minor child listed above hereby releases and agrees to hold harmless IPRF, St. Mary Parish, Appleton, St. Joseph Parish Appleton, CYMA, or any of its advisors, chaperones or persons connected with the event from liability, claims or damages for personal injury, property loss or other damage which may result during the above event.

The undersigned minor hereby agrees to abide by the rules established for this event:

Child's signature: \_\_\_\_\_ Birthdate \_\_\_\_\_

Address: \_\_\_\_\_ Grade: \_\_\_\_\_

City /Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

Email: \_\_\_\_\_ Parish: \_\_\_\_\_

According to Diocese of Green Bay policy, participants in parish events are to be covered by insurance for any travel, competition or performance. It is the responsibility of the parent to provide this insurance coverage. Contacts: please include one in addition to parent in the event that parent cannot be reached:

Parents phone(s): \_\_\_\_\_

Relative /Friend \_\_\_\_\_ Phone \_\_\_\_\_

Doctor \_\_\_\_\_ Phone \_\_\_\_\_

Dentist \_\_\_\_\_ Phone \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_

Please list any medical conditions which may effect your child's participation in this activity:

**Authorization for Medical Treatment**

I hereby authorize the treatment, administration of anesthesia, surgical treatment(s) for my minor child, \_\_\_\_\_ in the event of a medical situation occurring during my absence or when the hospital or physician are unable to contact me. This authorization extends to any hospital, physician(s), and medical personnel within the physicians' staff where treatment is rendered in the physicians office. I release from medical responsibility and liability the hospital, physician(s), and nursing personnel from performing medical procedures acting on the authority of this medical treatment consent form which such medical providers deem necessary for my minor child / ward.

Signed this \_\_\_\_\_ day of \_\_\_\_\_ and valid for one year.

\_\_\_\_\_  
Signature of Parent /Legal Guardian

Parent: I am willing to chaperone/drive \_\_\_\_\_