

### High School Fall Retreat Details

**Date:** Fri-Sun, Nov 18-20      **Meet at Church:** 7:30 pm Friday      **Return:** 3:00 pm Sunday  
**Cost:** \$20 & a snack to share      **Location:** Camp Fraser, Great Falls, VA      **RSVP by:** Monday, Nov 14  
**Other Details:** *Arrive on Friday after having eaten dinner! We will not have a meal Friday night.*

**BRING:**

- Sleeping Bag or Sheets & Blanket, Pillow
- Towel & Toiletries, Warm Clothes

**LEAVE AT HOME:**

- \*Cd Players, iPods, blackberries, etc.
- \*Homework & School Books, Cell Phones

Detach and retain this section for your information.

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Detach and return this section with payment by the RSVP deadline of Monday, November 14.

### High School Fall Retreat Permission Slip

As the parent/guardian of \_\_\_\_\_, I hereby give permission for my child to go to Camp Fraser Retreat Center in Great Falls, Virginia on Friday, November 10 until Sunday, November 20 for the Good Shepherd High School Fall Retreat.

I understand and acknowledge that participation in this activity involves inherent risks of injury to my child including risks associated with transportation by motor vehicle. I agree to indemnify the Parish, Youth Ministers, Volunteers, and the Diocese of Arlington for any costs or expenses arising out of my child's participation in this activity, including the cost of any medical care given my child or any expenses or fees incurred in any lawsuit arising as a result of any damage or injuries caused by my child in the course of his or her participation.

I further give my consent that in my absence the above-named minor be admitted to any hospital or medical facility for diagnosis and treatment. I request and authorize physicians, dentists, and staff, duly licensed as Doctors of Medicine or Doctors of Dentistry or other such licensed technicians or nurses, to perform any diagnostic procedures, treatment procedures, operative procedures and x-ray treatment of the above minor. I have not been given a guarantee as to the results of examination or treatment. I authorize the hospital or medical facility to dispose of any specimen or tissue taken from the above-named minor.

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Grade

\_\_\_\_\_  
Allergies or medical conditions/concerns (Continue on back of form if needed)

\_\_\_\_\_  
Name of Parent/Guardian

\_\_\_\_\_  
Address

\_\_\_\_\_  
City/State/Zip

Phone: Home

Work

Mobile

\_\_\_\_\_  
Person to notify if parent/guardian is unavailable

Phone: Home

Work

Mobile

\_\_\_\_\_  
Insurance Carrier & Policy Number

\_\_\_\_\_  
Family Physician Phone

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

\_\_\_\_\_  
Date