

PRIZE!
To the first
10 registered

ST. ROBERT'S YOUTH 6-12TH GRADE
CANNONBURG TUBING EXCURSION
6800 CANNONBURG ROAD
BELMONT, MI 49306
SATURDAY, FEBRUARY 2ND, 2019
REGISTRATION DEADLINE 1-23-19

NAMES OF PARTICIPANTS: _____

ADDRESS: _____

EMAIL: _____

PARENT PHONE
NUMBER: _____

NUMBER ATTENDING: ____ COST PER PERSON: 30.00 AMOUNT PAID: _____

MEET US AT ST. ROBERT CHURCH NO LATER THAN 9:30AM (BUSES WILL LEAVE AT 9:30AM
APPROXIMATE TRAVEL TIME IS 25 MINUTES).

1:30PM PARENT PICK UP AT ST. ROBERT CHURCH.

CONCESSIONS ARE AVAILABLE FOR PURCHASE IN THE LODGE.

PLEASE RETURN THIS FORM AND CANNONBURG LIABILITY WAIVER FORM TO:

FAITH FORMATION OFFICE
ST. ROBERT CHURCH
6477 ADA DRIVE SE,
ADA, MI 49301.
mrenauer@strobortchurch.org
616.676.9111 x118

TEAR HERE



SATURDAY, FEBRUARY 2ND, 2019
REGISTRATION DEADLINE 1-23-19
CANNONBURG TUBING EXCURSION
6800 CANNONBURG ROAD
BELMONT, MI 49306
LEAVING ST. ROBERT'S AT 9:30AM
RETURNING TO ST. ROBERT'S AT 1:30PM
EMERGENCIES ONLY:
MICHAEL RENAUER 517-574-9881

CONCESSIONS ARE
AVAILABLE FOR
PURCHASE IN THE
LODGE.

DON'T FORGET THE CANNONBURG LIABILITY WAIVER!

PHOTO RELEASE

I understand that through their participation in this program, my child(ren) listed on this registration may be photographed for use in promotion of diocesan programs.

As parent/legal guardian, I DO GIVE DO NOT GIVE permission for my child(ren) photographed during this program.

Parent Signature _____ Date _____

MEDICAL TREATMENT RELEASE

As a parent/legal guardian, I do hereby authorize first aid/medical treatment of my child in the event of an emergency which may endanger his/her life, cause disfigurement, physical impairment, or undue discomfort if delayed. It is understood that efforts will be made to reach me as soon as reasonably possible. In the event that the aforementioned required my authorization for treatment and I cannot be reached in an emergency, I hereby give my permission to the physician selected by the activity leader to hospitalize, secure medical treatment, and/or order an injection, anesthesia or surgery for the aforementioned as deemed necessary.

I understand that all reasonable safety precautions will be taken at all times by the parish and its agents during faith formation programs. I understand the possibility of unforeseen hazards and know the inherent possibility of risk. I agree not to hold St Robert of Newminster Parish, its leaders, employees, drivers, volunteers, or the Roman Catholic Diocese of Grand Rapids liable for damages, losses, diseases, or injuries incurred by the aforementioned.

Name of child(ren)		Relationship to you	
Reason for which release is intended:	Faith Formation Sessions & Activities	Children's Choir	
Address of child		Home Phone	
Parent Name		Mobile Phone	
Family Physician		Physician Phone	
Physician Address/City/State/Zip			
List allergies, current medications, glasses/contacts, physical/mental/learning disabilities, dietary needs, or other pertinent information:			
Health Insurance Information:			
Company		Policy #	
Group #		Contact #	

This release form is completed and signed of my own free will with the sole purpose of authorizing medical treatment under emergency circumstances in my absence.

I certify that I am (**check one**) **Custodial Parent** **Legal Guardian** of the minor child(ren) named above, and I agree to the above terms for myself and for my minor child(ren).

Parent Signature		Date
<input type="checkbox"/>	Check if online signature	