[](https://nam02.safelinks.protection.outlook.com/?url=https%3A%2F%2Ftrack.canva.com%2FCL0%2Fhttps%3A%252F%252Fwww.canva.com%252Fdesign%252FDAFib3Kh5Ck%252Fshare%253Finvite%3DtlBMgTgcTKIOIAugcH7IaA%2526utm_campaign%3Ddesignshare%2526utm_medium%3Demail%2526utm_source%3DshareButton%2F1%2F010001880125cf1b-0a70a36b-bdd6-4b15-a971-3705068b22f9-000000%2FHiwBpfspgGkmOHiuJ7nmFASgJR8itkfo50L4aU6x74Q%3D300&data=05%7C01%7C%7Cd5d36f26d11b4a3c677c08db50a2cd10%7Ca54192d98f824167ba15f0159a5c6254%7C0%7C0%7C638192432391515654%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000%7C%7C%7C&sdata=oYAXvXVI9VzfOHzZqEgBn1WQejqqxxwrrUygBiedFr0%3D&reserved=0)

**July 22 – 23, 2023**

**Doors open at 10:00 am Saturday, the retreat ends at 3 pm Sunday**

The Benedict Inn Retreat and Conference Center: 1402 Southern Ave. Beech Grove, IN

**A FEW THINGS YOU’LL NEED…**

* All retreat forms *including medication from for those who don’t have staff to dispense filled out* and turned in no later than July 6, 2023
* Bed linens (pillow), sheets, blanket or sleeping bag) beds are twin size
* Bath towel and wash cloth
* Toiletries (soap, shampoo, deodorant, toothpaste, toothbrush)
* A reusable water bottle that is labeled with your name
* Medications you will need for the whole retreat time
* Masks and personal hand sanitizer
* If possible: a folding camp chair (LABELED, PLEASE)

*NOTE: There will be optional water games on Saturday, so you many want to bring extra clothes if you intend to participate!*

***Questions? Contact Jenny Bryans at (317) 446-5507 or*** [***Jbryans@archindy.org***](mailto:Jbryans@archindy.org)

**THANK YOU TO OUR SPONSORS:**

Logo, company name

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**CIRCLE OF FRIENDS summer Retreat Response Form**

Participants

Please return by **July 6, 2023** with payment;

(*Checks Payable to ARCHDIOCESE OF INDIANAPOLIS*)

**Mail To:** 1400 N Meridian Street; Indianapolis IN 46202

Contact Jenny Bryans at (317) 236-1448 or [jbryans@archindy.org](mailto:jbryans@archindy.org) for assistance.

* **Full Retreat Registration ($85 shared room, $90 for single room)**
* **Days Only (no overnight) ( $12 per meal, $10 for a tee-shirt)**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

Phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

T-Shirt Size: (Circle one) SM MED LARGE XL XXL Other (Specify) \_\_\_

**Emergency Contact Information *(Please provide two contacts)***

(1) Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number(s): 1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(2) Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number(s): 1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medication/Dosage Instructions:**  ***Please use medication form provided***

**ALL MEDICATIONS MUST BE CHECKED IN WITH THE NURSE**

***(Unless you have staff who assist with your medication)***

**Food Allergies/Restrictions/Special Instructions:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Assistance needed for**: *(Please check all that apply and explain)*

Dressing \_\_\_ Toileting \_\_\_ Bathing \_\_\_ Medication \_\_\_ Meals \_\_\_\_ Other \_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**PLEASE TURN FORM OVER 🡪**

**What would you want someone new to know about you (the participant)?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Staff Contact Information:**

* I (This participant) will have staff accompanying me (him/her)

Staff Name (if known): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Staff Contact Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Agency Emergency Contact Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Roommate Request (for shared rooms): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Other helpful information (routines, care needs, calming strategies, triggers, etc.)**

***Please include any recent significant life events or changes.***

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Who will pick up participant at the end of the retreat, 3PM on Sunday, July 23?**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Circle of Friends SUMMER RETREAT 2023**

**HEALTH FORM**

|  |  |
| --- | --- |
| Return all signed forms to:  Jenny Bryans  1400 N. Meridian Street  Indianapolis, IN 46202  [jbryans@archindy.org](mailto:jbryans@archindy.org) | **Please Note:**  Having adequate information about our participants is crucial to our ability to provide a safe and supportive environment.  *For this reason, we cannot allow anyone to participate in the retreat without a completed health form.* |

Participant’s Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sex (circle one) male female Birthdate: \_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_\_

**Allergies:** Check those that apply

* No known allergies
* Allergic to this food (s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Causes Anaphylaxis? YES NO

* Allergic to this medication(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Causes Anaphylaxis? YES NO

* Allergic to the following: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Causes Anaphylaxis? YES NO

**Nutrition/Diet:** Please note that we can work with some medically prescribed diets, but not necessarily individual food preferences. Please call if you have any questions.

* Eats a regular diet
* Vegetarian
* Gluten free
* Lactose intolerant
* Other (please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PLEASE TURN FORM OVER**

**Chronic Health Concerns:**  Check those that apply

* No chronic health concerns
* Has the following chronic health concern (s)

|  |  |
| --- | --- |
| * + Asthma   + Headaches   + Sleepwalking   + Diabetes   + Menstrual cramps   + Frequent ear infections | * + Fainting   + Incontinence   + Seizures   + Surgical history of consequence   + Other (describe below) |

Information about the items above (attach additional info if needed): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Medication:** “Medication” is any substance a person takes to maintain and/or improve his or her health, including over the counter medications, vitamins and homeopathic remedies.

* This person will not take any medications while attending the retreat
* All medications the participant will take are listed on the attached form.
* This person has staff who will administer medication- *YOU DO NOT NEED TO COMPLETE THE MEDICATION FORM*

**Note: *IF you do not have staff dispensing medication*, ALL medication must arrive in the original appropriately labeled containers and given to the nurse upon arrival.**

**Please contact Mary Roesinger (317) 902-7481 if you have any questions.**

**Mental, Emotional, Learning and Social Health:** Check each statement that applies

* This person has been diagnosed with a condition that impacts learning (e.g. ADHD, sensory processing problem, etc.)
* This person has a mental health diagnosis such as depression, OCD, panic/anxiety disorder
* This person has an emotional health concern (please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Information about the items above (attach additional info if needed): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL TREATMENT RELEASE**

Archdiocese of Indianapolis Policy Statement 2008-02 recognizes that parents (guardians) have the primary responsibility for the health of their dependent Although it is strongly recommended that medication be administered at home, the health of some adults with disabilities may require that they receive medication or other medical care while in the care of the Circle of Friends Summer Retreat. This also applies to non-dependent adult participants.

***If a medication must be taken while at the retreat, please be advised of the following:***

* When medication absolutely must be taken at other times outside the home, parents (guardians) or non-dependent adult participant shall provide explicit written instructions including, in some cases, instructions as necessary from a medical practitioner regarding the need for medication or specific medical care.
* Parents (guardians) and non-dependent adults signing this form are, in most cases, providing written permission for volunteer nurses to oversee the **self-administration** of medication or necessary routine medical care **by the participant** depending upon age and capability.
* *Participants* are not permitted to carry or keep medications (including analgesics, herbs, enzymes, oils, etc.) on their person, ***except for inhalers or other medical devices with specific permission***. Medications will be secured during the retreat for the protection of all participants.
* If a participant has staff who in the normal course of their duties dispense or oversee self-administration of medication, ***the staff member may retain and secure that participant’s medication*.**
* All medication is to be delivered and taken home by the parent (guardian) or non-dependent adult at registration and at end of the retreat.
* All medication is to be taken in the presence of a volunteer nurses and documented in a confidential log.
* **No medication** of any kind is to be provided by the retreat staff or volunteer nursing personnel.
* Prescription medication must be in the original pharmaceutically dispensed and labeled container. The prescription label will be considered the written order of the medical practitioner in most cases.
* Non-prescription medication must be in the original container in which it was purchased. Please provide medicine cups/spoons as necessary for liquid medication.
* If a staff person will be retaining and overseeing the medication of a participant, the nursing staff will still be provided with a list of that participant’s medications.

Permission to Participate and Appointment of Agent

**CONSENT**

I hereby consent for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to participate in The Circle of Friends Summer Retreat from July 21-23, 2023.

***I acknowledge that I have received information about the program and consent to (his or her participation).***

**WAIVER AND RELEASE**

I release and waive, and further agree to indemnify, hold harmless or reimburse the *Archdiocese of Indianapolis*, its successors and assigns, its members, agents, employees, and representatives thereof, as well as volunteer mentors, from and against, any claim which I, any other parent or guardian, any sibling, the participant, or any other person, firm or corporation may have or claim to have, known or unknown, directly or indirectly, from any losses, damages or injuries arising out of, during or in connection with the above named individual’s participation.

I hereby authorize a representative of the *Circle of Friends Summer Retreat Staff* as my agent. My agent may consent to the above-named participant’s: transportation by ambulance, examination, x-rays, diagnosis, hospitalization, anesthesia, medication and any emergency medical treatments that are necessary in the best judgement of the healthcare providers.

Participant Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Name (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Phone: (H) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (C) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Participant Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Heath Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Parent/Guardian or Non-Dependent Participant Date

**Permission to use Photograph or Likeness**

Name of Subject: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I do permit and authorize the Archdiocese of Indianapolis (hereafter, the Archdiocese) and its

employees, agents and personnel who are acting on behalf of the Archdiocese to use my photograph or other likeness and appropriate identifying or accompanying information for purposes related to the educational and ministerial mission of the Archdiocese, including publicity, marketing, and promotion of the Archdiocese and its various programs and ministries.

I understand my photograph or likeness may be copied and distributed by means of various media, including video presentations, news bulletins, signs, brochures, placement on websites or in

newspapers.

I understand that, although the Archdiocese will endeavor to use my photograph or likeness and

identifying and accompanying information in accordance with the standards of good judgment, the

Archdiocese cannot warrant or guarantee that any further dissemination of my photograph or likeness and information will be subject to Archdiocesan supervision or control. Accordingly, I release the Archdiocese of Indianapolis from any and all liability related to dissemination of my photograph or likeness.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Parent or Guardian (if subject is under 18, or a dependent adult):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_