2008 EMMAUS DAYS REGISTRATION FORM (ADULT-18 & OLDER)

(Return all forms ***two weeks prior to the beginning of the session*** *you would like to attend.)*

PERSONAL INFORMATION

NAME ______________________ AGE

BIRTHDATE ______________________

ADDRESS ______________________

CITY ______ STATE ______ ZIP ______

EMAIL

PHONE (   ) ______________________

SCHOOL ______________________

GRADE LEVEL ______ For : 2008-2009 __

PARISH INFORMATION

PARISH NAME ______________________

ADDRESS ______________________

CITY ______ STATE ______ ZIP ______

PASTOR ______________________

Parish Fee $95

Pastor's Signature:

______________________ Date:________

Applicant's Fee $60

Check the box *of the session you would like to attend.*

☐ *Session I: (H.S. Graduates and older)*
June 6-9, 2008
King's House- Henry, IL

☐ *Session II: (Juniors and Seniors)*
June 27-30, 2008
King's House- Henry, IL

☐ *Session III: (Freshmen and Sophomores)*
July 6-9, 2008
St. Bede Abbey- Peru, IL
Circle T-shirt size: S M L XL

☐ *Session IV: (7th and 8th Graders)*
July 9-11, 2008
St. Bede Abbey- Peru, IL
Circle T-shirt size: S M L XL

I previously attended Emmaus Days

YES ________ NO________

If **YES,** list years ______________________

If **NO,** I heard about Emmaus Days from - (Check all that apply)

_____Priest _____Seminarian

_____Family _____ Teacher

_____Friend _____Other

Make Checks Payable To:
THE CATHOLIC DIOCESE OF PEORIA

Mail Materials Back To:
OFFICE OF VOCATIONS
512 E. KANSAS STREET
PEORIA, IL 61603

For Office Use Only

Parish Fee Paid__________________ Applicant Fee Paid________________

MEDICAL INFORMATION

PARTICIPANT:

Name (first, middle, last): ______________________________

Address: ______________________________

____

EMERGENCY CONTACTS:

Parent(s) or Guardian

Name (First, middle, last): ______________________________

Phone (include area code): ______________________________

Other Contact

Name (first, middle, last): ______________________________

Relationship (friend,
Relative, neighbor, etc): ______________________________

Phone (include area code): ______________________________

STUDENT/MINOR's REGULAR PHYSICIAN:

Name (first, middle, last): ______________________________

Phone (include area code): ______________________________

MEDICAL CONDITIONS:

Please list any medical conditions of the above student/minor (asthma, diabetes, epilepsy, etc.):

____

____

____

____

Please list any allergies or allergic reactions to medications of the above student/minor:

____

____

____

____

Please list any medications the above student/minor is now taking:

____

____

____

____

Date of student/minor's most recent tetanus shot:

____

____

Other pertinent medical information:

____

____

____

____

MEDICAL INSURANCE INFORMATION:

Company (primary medical provider): ______________________________

Phone Number (include area code): ______________________________

Identification number of plan: ______________________________

Identification # of covered employee: ______________________________

Authorization for Emergency Medical Treatment
Overnight Activity

This information will be kept in the possession of The Office of Vocations and distributed to the person in charge of this activity. Should the need arise, this information will be given to the proper medical authorities.

I, ________________________, understand that in the case of my illness, The Office of Vocations, will try to notify the person I have listed below as an emergency contact.

In case of medical emergency concerning myself, at a time when my listed emergency contact cannot be notified, I grant full power to The Office of Vocations and/or any supervising employee to do as follows.

1. Arrange for the transportation of myself, whether by ambulance or otherwise, to a proper facility where emergency medical treatment would normally be administered, including but not limited to, an emergency room of a hospital, a doctor's office, or a medical clinic; and

2. Sign releases as may be required in order to obtain any medical or surgical treatment as is required in the judgment of medical authorities at the facility.

____
Signature

____
Printed name

Date: ______________________________

STATE OF ILLINOIS)
) SS.
COUNTY OF ___________)

SIGNED AND SEALED before me this ____ day of _____________, 20___.

____
NOTARY PUBLIC

2/20/03
Adult

ADULT HOLD HARMLESS/INDEMNITY AGREEMENT

PARISH: **KING'S HOUSE OF RETREAT and/or ST. BEDE ABBEY**

PARISH is understood to include the CATHOLIC DIOCESE OF PEORIA

ACTIVITY PARTICIPANT OR FACILITY USER: ______________________________

DATES OF ACTIVITY OR USAGE: ______________________________

TYPE OF ACTIVITY OR USAGE: **EMMAUS DAYS**

The above named ACTIVITY PARTICIPANT OR FACILITY USER agrees to defend, protect, indemnify and hold harmless the above named PARISH against and from all claims arising from the negligence or fault of the above named ACTIVITY PARTICIPANT OR FACILITY USER or any of their agents, family members, officers, volunteers, helpers, partners, organizational members or associates which arise out of the above named ACTIVITY OR USAGE at the above named PARISH.

Additionally, the above named ACTIVITY PARTICIPANT OR FACILITY USER agrees to protect, defend, hold harmless and fully indemnify the above named PARISH for any claim or cause of action whatsoever arising out of the above mentioned ACTIVITY OR USAGE which takes place during the above identified DATE(S) OF ACTIVITY OR USAGE that is brought against the PARISH by the above named ACTIVITY PARTICIPANT OR FACILITY USER or their family members whether such claim arises from the alleged negligence of the PARISH, its employees or agents or ACTIVITY PARTICIPANT or FACILITY USER'S negligence. If any portion of this agreement is held invalid, it is agreed that the balance thereof, shall continue in full legal force and effect.

SIGNED BY: ______________________________

NAME (please print): ______________________________

DATE: ______________________________