

Altar Server Outing St. John the Evangelist



REGISTRATION FORM

Each participant needs to complete a separate registration form.

NAME: _____ AGE: _____ HEIGHT: _____

Make your selection below:

- | | | | |
|---|---|------|-------------|
| <input type="checkbox"/> Altar Server (<i>Ticket, lunch, pavilion, & Bus</i>) | = | \$ | <i>Free</i> |
| <input type="checkbox"/> Youth Ticket (<i>includes lunch & pavilion</i>) | = | \$50 | \$ _____ |
| <input type="checkbox"/> Adult Ticket (<i>includes lunch & pavilion</i>) | = | \$50 | \$ _____ |
| <input type="checkbox"/> Bus Transportation (<i>per person</i>) | = | \$5 | \$ _____ |

TOTAL: \$ _____

- Will Travel Separate (*meet at Water Wizz by 9:45am*)

(Cash – Venmo - or check payable to: St. John’s Parish)

(Permission slip required – reverse side)



venmo

PERMISSION & MEDICAL INFORMATION

PARENTAL CONSENT FORM/LIABILITY WAIVER

Participant's name: _____ Date of birth: _____ Sex: ___ Height: _____

Parent/Guardian's name: _____

Home address: _____ Cel Phone: _____

I, _____ grant permission for my child, _____
Parent or guardian's name participant's name

to participate in this parish event that requires transportation to a location away from the parish site. This activity will take place under the guidance and direction of Our Lady of Guadalupe Parish and/or volunteers from the Parish.

Type of event: **Youth Outing to Water Wizz Water Park in Wareham, MA** Date of event: **August 12, 2026**

(Depart church via bus @ 9AM; return to church approx. 5PM) Individual in charge: **Rev. Craig A. Pregana**

As parent and/or legal guardian, I remain legally responsible for any personal actions taken by the above named minor ("participant"). I agree on behalf of myself, my child named herein, or our heirs, successors, and assigns, to hold harmless and defend **St. John the Evangelist Parish**, its officers, directors, employees and agents, and the **Diocese of Fall River**, its employees and agents, chaperons, or representatives associated with the event, from any claim arising from or in connection with my child attending the event or in connection with any illness or injury (including death) or cost of medical treatment in connection therewith, and I agree to compensate the parish, its officers, directors and agents, and the Diocese of Fall River, its employees and agents and chaperons, or representative associated with the event for reasonable attorney's fees and expenses which may incur in any action brought against them as a result of such injury or damage, unless such claim arises from the negligence of the parish or the Diocese of Fall River.

MEDICAL INFORMATION

(Of the following statements pertaining to medical matters, sign only those that are applicable.)

MEDICAL MATTERS: I hereby warrant that to the best of my knowledge, my child is in good health and I assume all responsibility for the health of my child.

- **Emergency Medical Treatment:** In the event of an emergency, I hereby give permission to transport my child to a hospital for emergency medical or surgical treatment. I wish to be advised prior to any further treatment by the hospital or doctor. In the event of an emergency, if you are unable to reach me at the above numbers, contact:

Emergency Contact Name: _____ Relationship to child: _____

Cel Phone: _____ Family doctor: _____ Phone: _____

Family Health Plan Carrier: _____ Policy #: _____

Parent Signature: _____ Date: _____

- **Medications:** My child is taking medication at present. My child will bring all such medications necessary and such medications will be well-labeled. Names of medications and concise directions for seeing that the child takes such medications, including dosage and frequency of dosage, are as follows:

Medication: _____ Dose/Frequency: _____

Parent Signature: _____ Date: _____

- I hereby grant permission for non-prescription medication (*i.e. non-aspirin products such as acetaminophen or ibuprofen, throat lozenges, cough syrup*) to be given to my child, if deemed appropriate.

Signature: _____ Date: _____

- **Specific Medical Information:** Allergic reactions (*medications, foods, insects, etc.*): _____

Date of last tetanus/diphtheria immunization: _____ Physical Limitations? _____

Does child have a medically prescribed diet? _____

Has child recently been exposed to contagious disease or conditions? _____

Other special medical conditions of my child: _____

Signature: _____ Date: _____