

# Chicago Urban Immersion Experience

WHEN: June 16-19.

COST \$170.00\*

This event has a limited number of openings and will be filled on a first come first served basis.

My son/daughter has my permission to attend the Urban immersion trip

\*cost is \$225 for non-St Bernadette Parishioners I authorize transportation to and from Chicago and through out the event to worksites and other areas of interest. I further release the advisors, chaperons, parish, its staff and volunteers from any liability in the event my son/daughter is injured while participating in this event

The participants will be housed at the Br Darst Center 2834 S. Normal Chicago Il.

Participant name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ M / F  
Address: \_\_\_\_\_ Grade: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Parent' Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Parent willing to chaperone?  Yes  No Work phone: \_\_\_\_\_  
Emergency Contact: Name: \_\_\_\_\_ Relationship to student \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Insurance Company: \_\_\_\_\_ Group # \_\_\_\_\_

*According to Green Bay Diocesan policy, participants are to be covered by insurance for any travel, competition or participation. It is the responsibility of the parent/guardian to provide this insurance coverage.*

PLEASE LIST ANY MEDICAL CONDITIONS, WHICH WOULD AFFECT THE STUDENT'S PARTICIPATION IN THE EVENT, OR ANY MEDICATIONS THE STUDENT MAY BE TAKING DURING THE EVENT

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

I hereby authorize the treatment, administration of anesthesia, surgical treatments for my minor son/daughter in the event of a medical situation occurring during my absence or when the hospital or physicians are unable to contact me. This authorization extends to any hospital, physicians and nursing personnel within the physicians' staff where the treatment is rendered in a physician's office. I release from medical liability the hospital, physician(s), and nursing personnel for performing medical procedures acting on the authority of this medical treatment consent from which such medical providers deem necessary for my minor son/daughter.

Signed this \_\_\_\_\_ day of \_\_\_\_\_ and valid through June30, 2010

\_\_\_\_\_  
*signature of parent*