NWLA ACTS RETREAT REGISTRATION FORM

ACTS Men's Retreat April 4-7, 2019

The ACTS retreat weekend is hosted by lay members of several local parishes/churches who have themselves been on an ACTS retreat. The goal of the retreat is to deepen your relationship with Jesus Christ, to receive spiritual renewal, to give new meaning to Sunday liturgy and your prayer life, and to build lasting relationships with other members of our community.

NOTE: Due to Diocesan Policy, all applicants must be over 18 years of age at the time of the retreat.

The retreat begins on Thursday, April 4th and ends on Sunday, April 7th following the 12:00 pm Mass at St. Joseph Catholic Church in Shreveport. After Mass, there will be a welcome back reception in the St. Joseph Family Life Center. Round trip transportation from St. Joseph is provided for all retreatants. You will meet for send-off at the St. Joseph Family Life Center on Thursday evening 4/4 at 5:00 PM.

The cost of the retreat (room and board) is $185.00. Your deposit of $75.00 must be submitted with this form in order to reserve your place. The remaining $110.00 is due Thursday at send off. **Please make your checks payable to St. Joseph Catholic Church**. Post Dated Checks will not be accepted and all checks will be processed and deposited upon receipt. We will not hold checks. There will be a $25 fee for all returned checks. If a retreat date becomes full, your deposit will be returned to you and you may register when registration begins for the next retreat date.

Please note: Financial difficulties should not prevent anyone from attending the retreat. If you are unable to pay all, or part of the fee, financial arrangements can be made by notifying retreat director **Ken Mitchell (318) 470-5649**

REGISTRATION FORM, HOLD HARMLESS AGREEMENT, AND EMERGENCY MEDICAL AUTHORIZATION FORM MUST BE MAILED WITH YOUR CHECK TO THE FOLLOWING ADDRESS: NWLA ACTS P.O. Box 52761 Shreveport, LA 71135
These forms can only be accepted by mail and registration is not complete until all forms are filled out completely.
We do not accept forms that are handed in, as each form is numbered as it is received in the mail.
You will be notified by A.C.T.S. when ALL forms and check have been received.
Please contact the Director if you are not notified of receipt within 3 weeks of mailing

_____ _____
Name Please Print Clearly Circle T-shirt size: S, M, L, XL, 2 XL, 3 XL Name as you want it to appear on your Name Tag

_____ _____ _____ _____
Address City ST ZIP

_____ _____ _____
Home Phone Work Phone Cell Phone

_____ _____
Email Address Please Print Clearly Date of Birth

Please provide the following for three (3) emergency contacts:

_____ _____ _____
Family member / Friend Home Phone/Mobile Phone Work Phone

_____ _____ _____
Family member / Friend Home Phone/Mobile Phone Work Phone

_____ _____ _____
Family member / Friend Home Phone/Mobile Phone Work Phone

List special dietary or medical needs, if any: _____

Do you have trouble climbing stairs? Yes / No (circle one)

What is the name of the church that you attend? _____ _____
Name City

_____ I have included my deposit of $75.00 OR _____ I have included the entire fee of $185.00 OR _____ I have included partial payment with scholarship need

CORE Release Date: August 11, 2012 / CORE Revision Date January 4, 2019

For internal use only –
Date received _____

HOLD HARMLESS AGREEMENT

"To the fullest extent permitted by law, _____ releases and
(Participant)
agrees to defend, pay on behalf of, indemnify, and hold harmless the Diocese of Shreveport and St Joseph Catholic Church (collectively, the "Sponsor"), its elected and appointed officials, its agents, employees and volunteers and others working on behalf of the Sponsor against any and all claims, demands, suits, or loss, including attorney's fees and all costs connected therewith, and for any damages which may be asserted, claimed or recovered against or from the Sponsor, its elected and appointed officials, its agents, employees, volunteers, or others working on behalf of the Sponsor, by reason of personal injury, including bodily injury or death and/or property damages, including loss of use thereof, suffered by Participant.

Dated: _____ , 2019 _____
Participant

WITNESSES:

_____
(Signature)
Printed Name: _____

_____
(Signature)
Printed Name: _____

ST JOSEPH CHURCH
EMERGENCY MEDICAL AUTHORIZATION

Name of Participant: _____
Social Security Number: _____
Home Phone Number: _____
Street Address: _____
City, State, Zip: _____

PURPOSE: To enable participants to authorize emergency treatment should they become ill or injured while participating in church-sponsored event.

PART I OR PART II AND PART III MUST BE COMPLETED.

PART I – GRANT CONSENT In the event reasonable attempt to contact designated individuals as follows:

Emergency Contact: _____ Relation: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
or

Emergency Contact: _____ Relation: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____

Have been unsuccessful, I hereby give my consent for (1) administration of any treatment deemed necessary by:
Preferred Physician: _____ Office Phone: _____
Physician #2: _____ Office Phone: _____

Or (2) in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and transfer of the participant to _____ (preferred hospital) or any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring the necessity for such surgery, are obtained before surgery is performed.

I, the undersigned, understand that participation in activities inherently involve risk, including injury. As such, I hereby release, waive, discharge, and covenant not to sue from any loss, damage, or injury, including death, that may be sustained by myself, whether caused by negligence while participating in such activity where the activity is being conducted.

Facts concerning my medical history including allergies, medications being taken, and any physical impairments to which a physician should be alerted:

_____ _____
Date Signature of Participant

_____
Address

PART II – REFUSAL TO CONSENT

I do not give my consent for emergency treatment of myself. In the event of illness or injury requiring emergency treatment, I wish the church authorities to take no action or to:

_____
_____

_____ _____

Date Signature of Participant

PART III

Please list below any information regarding ongoing medical conditions or medications (ex. Bee stings, diabetes, etc.)

_____
_____
_____
_____
_____
_____
_____

Drug allergies, if any:

_____
_____
_____