THE DIOCESE OF PROVIDENCE INVITES YOU TO...

# PHASE 2

"Little People Doing Big Things"

JULY 8TH, 10AM TO JULY 9TH, 11AM
FR. MAROT CYO CENTER
53 FEDERAL STREET
WOONSOCKET RI

Open to all youth under 21 who have attended Search
$35.00 per person

For more information contact the Fr. Marot CYO Center
at 401-762-3252
or Rejoice in Hope Center at 401-942-6571
www.catholicyouthri.org

FREE Transportation from Rejoice in Hope Youth Center,
Cranston to Fr. Marot CYO Center, Woonsocket

## Participant Information (Please Print)

Name _____ Female/Male (please circle) Month/Year of Birth _____

Address _____

(Street) (City) (St) (Zip)

Phone _____ Email _____

Parish/City _____ School _____ Grade _____

## Parent/Guardian Information (Please Print)

Name _____

Address (if different from above)_____

(Street) (City) (St) (Zip)

Phone_____ Email_____

## Registration Information (Please Print)

Registration Fee ($35.00) Amount Included $ _____ Amount Due $_____

**Parent/Guardian Release and Consent & Medical Information**
**If 18 or older please sign for yourself!!**

I, (parent/guardian) _____, the undersigned, give permission for my child/ward _____ to attend the Phase II to be held at the _____ Center on (date) _____, and agree to release, exonerate, indemnify and defend the Roman Catholic Bishop of Providence, the Catholic Youth Organization of the Diocese of Providence, my parish _____ and the CYO of Northern Rhode Island, Inc. from all claims arising from, or occasioned by my child's/ward's attendance at this event.

I also grant permission if needed for my child/ward to be evaluated, diagnosed, treated and/or medicated in accordance with standard medical practice by licensed medical personnel. I relieve the Roman Catholic Bishop of Providence, the Catholic Youth Organization of the Diocese of Providence and the CYO of Northern Rhode Island, Inc. of all responsibility and consequences that may arise as a result of this treatment. I will not hold any of the parties listed above or representatives associated with the program responsible in the event of injury. Further I agree to accept any financial responsibility as a result of scheduling such treatment.

I GRANT PERMISSION for the adult chaperones for this event to administer non-prescription drugs as needed for my child/ward (aspirin, ibuprofen, antacids, etc.) ____ Yes ____ No

I AUTHORIZE the Catholic Youth Organization of the Diocese of Providence to use photographs/videos of my child/ward for productions, publications, etc. ____ Yes ____ No

Parent Name _____ Parent Signature _____ Date _____

My child is allergic to: _____ My child must take the following medication(s): _____
Dosage: _____ Frequency _____

You should be aware of the following health/medical conditions of my child:
_____

Parent/Guardian name: _____ Phone # _____
Other ways to reach (i.e. cell phone, work phone - please specify):
_____

If parent/guardian cannot be reached in the event of an Emergency, please notify:_____

Phone #_____ Alt Phone # _____ Relationship to Youth _____