

Payment enclosed: \$25 Deposit _____ \$35 Paid in Full _____ First Choice Date _____ Date Received _____

Make check payable to "Southwestern Indiana TEC"

Upon receipt of this application, you will be notified about acceptance. Openings on a particular weekend may not be immediately available. Candidates are placed on a "first come – first served" basis.

***MAIL APPLICATION TO: SARA KESSENS * 647 w 1100 s * FERDINAND, IN 47532 * (812) 367-1069*
TSKES@PSCI.NET**

TEC APPLICATION

Name _____ Sex _____ Age _____ Birthdate _____

Address _____ City, State, Zip _____

Phone _____ Email address _____

School (if appropriate) _____ HS Graduation Year _____

Parish _____ Pastor or Youth Minister _____

Parent's Names _____

How many brothers? _____ Sisters? _____ Have they made TEC? _____

Describe any medical, physical, or dietary needs: _____

Describe your parish and school involvement: _____

Why do you want to make a TEC? _____

***What is your religious denomination, if other than Catholic? _____**

Who is your patron Saint? (i.e. your Confirmation name, etc.) _____

Have your Sponsor complete this section:

Candidate's Leadership Qualities: Little _____ Average _____ Strong _____

Participation in a group: Quiet _____ Average _____ Talkative _____

Any other comments: _____

Recommendation: I recommend that this person be considered as a youth participant for the Teens Encounter Christ Retreat.

Pastor's / Youth Minister's / Sponsor's Signature: _____

WAIVER, RELEASE, AND MEDICAL INFORMATION CATHOLIC DIOCESE OF EVANSVILLE & TEC

This Section MUST be completed if the youth is under age 18 at the start of the retreat.

I/We, the guardian(s) of the above named youth, hereby give my/our approval for his/her participation in the Teens Encounter Christ retreat event. I/We assume all risks and hazards incidental to the conduct of the activities and transportation to and from the event. I/We do further hereby waive, release, absolve, indemnify, and hold harmless the Bishop of the Catholic Diocese of Evansville, Southwest Indiana Teens Encounter Christ, and any of their respective affiliates, successors, agents, employees, members, and representatives, adult sponsors, and other volunteers involved in the activities and transportation associated with the event from any and all claims, including claims of personal injury to my/our youth or property damage, under any theory of law (including negligence, but not reckless or intentional conduct) in any way resulting from or arising in connection with the activities and/or transportation to and from the event. In case of accident or serious illness I request the TEC Lay Director to contact me. If I cannot be reached, I hereby authorize the TEC Retreat Leadership to make whatever arrangements the circumstances allow. It is understood and agreed that neither the Parish, TEC Leaders, nor the Catholic Diocese of Evansville is the insurer of my child's health and safety while he/she is at youth functions or engaged in supervised activities, including sports. I understand it to be my obligation to provide such insurance as I may desire to purchase to protect myself and my child against the costs of sickness or injury. If the above-named child needs emergency medical treatment, and neither a parent nor the designated family physician can be contacted, consent is hereby granted for such emergency treatment as may be considered necessary in the opinion of the attending physician.

Guardian's Signature X _____ Date _____

EMERGENCY INFORMATION

Family Name _____ Address _____ City, State, Zip _____

Phone _____

If Guardian cannot be reached, call (name) _____ Phone _____

Family Physician _____ Phone _____

Name of Family Insurance Carrier/Phone #: _____ Policy # of insurance policy _____

Is there anyone who by court order or decree is designated as the primary or sole custodial parent? _____

Name anyone who has been restrained from picking up the child _____

I understand it is my responsibility to keep the TEC Community informed about such matters and to provide copies of relevant court orders and decrees to officials.

AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATION BY AUTHORIZED PERSONNEL

I HEREBY AUTHORIZE PERSONNEL TO ADMINISTER MEDICATION AS INDICATED TO:

Name: _____ Rx Number: _____ Name of Medication: _____

Directions: _____ Doctor: _____

Phone: _____ Pharmacy: _____ Phone: _____ Time(s) medication is given at home: _____

Time(s) medication is to be given at the event: _____

I UNDERSTAND THAT MY SIGNATURE RELIEVES THE TEC PERSONNEL OF ANY AND ALL LIABILITY RELATED TO THE ADMINISTRATION OF THE PRESCRIBED MEDICATION.

Signature of Guardian X _____ Date: _____ Cell # during the event: _____