



CONSENT FORM (18 and OVER)

I hereby indicate my intention to attend the Holy Spirit Teen and Young Adult Retreat at the Landmark Hotel in Metairie, LA, on January 6-8 2012.

I understand that this event is under the sponsorship of the office of the Catholic Charismatic Renewal of New Orleans (CCRNO) and I certify that I will submit to the reasonable and legitimate requirements necessary for good order while attending this event. If either medical or behavioral problems arise involving me, I further understand and agree that the said sponsor and its representatives reserve the right to immediately return me home and that any travel expenses incurred will be my responsibility.

I do hereby voluntarily appoint a CCRNO representative as my health care representative. He is hereby authorized to act for me and on my behalf in all matters of surgical or medical treatment. This appointment terminates upon my return home from the Holy Spirit Teen and Young Adult Retreat.

If I have no insurance or if my health insurance fails to pay all or part of any medical expenses incurred by me, I understand and accept that I am ultimately responsible to pay for any and all my medical expenses and that CCRNO is not responsible to pay these expenses.

HEALTH INSURANCE COMPANY _____ HEALTH PLAN _____
NUMBER _____
HEALTH INSURANCE COMPANY'S TELEPHONE NO. (____) _____

RELEASE OF LIABILITY- ARCHDIOCESE OF NEW ORLEANS

I, (print name) _____, agree on behalf of myself, my heirs, assigns, executors, and personal representatives, to hold harmless and defend **the Catholic Charismatic Renewal Of New Orleans Office, the Archdiocese of New Orleans, its officers, directors, agents, employees, or representatives** associated with the Holy Spirit Youth and Young Adult Retreat from any and all liability claims, loss or damage arising from or in connection with my participation in this event.

Address: _____

Phone #: (Home) _____ Social Security #: _____

Phone #: (Work) _____ Signature: _____

PLEASE MAKE SURE THAT BOTH SIDES OF THIS FORM ARE FILLED OUT.

Catholic Charismatic Renewal of New Orleans
PO Box 7515, Metairie, LA 70010-7515, 1901 Division St, Metairie, LA 70001
info@ccrno.org * 504-828-1368 * www.ccrno.org * Fax: 504-831-5810

NAME: _____

MEDICAL FORM

QUESTIONS:

1. Are you allergic to any medications? _____ If so, What? _____

2. Please list any other allergies: _____

3. Have you ever had surgery? _____ Have you ever been Hospitalized? _____

4. Please list any disabilities or handicaps: _____

5. Are you under the care of a physician for any medical problems? _____

6. Do you take medication(s)? _____ If so, please identify: _____

7. Do you have any special medical needs that we should know about? _____

Please specify: _____

PLEASE MAKE SURE THAT BOTH SIDES OF THIS FORM ARE FILLED OUT.

**FORM MUST BE MAILED OR BROUGHT TO CCRNO, PO BOX 7515, METAIRIE, LA 70010-7515
OR CCRNO (ST BENILDE PARISH CENTER) 1901 DIVISION ST, METAIRIE, LA 70001**

NO ONE MAY ATTEND RETREAT WITHOUT A SIGNED FORM.