

Each Troop Leader **MUST HAVE** a completed and signed permission slip for each scout and Adult Chaperone participating in the Scouting Retreat. In. addition, each Troop Leader **MUST BRING** these permission slips with them to the retreat

DIOCESE OF MANCHESTER – PERMISSION SLIP

41st ANNUAL HIGH ADVENTURE SCOUT RETREAT!!!

At Camp Fatima, 32 Fatima Rd., Gilmanton Iron Works NH 03837

Our Websites: www.catholicnh.org and www.facebook.com/nhscoutretreat

For Information: nhcatholicscouting@gmail.com

ACTIVITY: Retreat includes High Ropes Challenge and a Climbing Wall as well as camping, scouting and religious activities

DATE OF ACTIVITY AT CAMP FATIMA:

Arrival time: Friday September 15, 2023, 6-8pm

Departure Time: Sunday, September 17, 2023, 11:30am

DEPARTURE TIME: _____ PLANNED RETURN TIME: _____

TRANSPORTATION BY: _____ BUS _____ PERSONAL CAR (Employee/Volunteer Driver)

NAME OF MINOR CHILD/WARD: _____

Please allow my child/ward to participate in the activity listed above. My child/ward is physically fit and capable of taking part in this activity.

I agree to have my child transported via ambulance and/or treated for emergency medical or dental problems if an emergency arises. I accept full responsibility for all medical expenses incurred as a result of my child/ward's participation in this program.

On the lines below I have listed any medical condition, physical disability, allergy to medicine, etc. which is relevant to rendering medical care to my child if s/he needs emergency medical care:

I understand that photographs of my child may be taken & used for publicity, newspaper articles, and/or on the Catholic Scouting section of the Diocese of Manchester website and social media pages.

During this activity, I can be reached at this phone number(s): _____

Signed this _____ day of _____, 2023.

Parent/Guardian Name (print)

Parent/Guardian (Signature)

For Adult Chaperones

I voluntarily agree to assist in the above activity. I give permission to be transported via ambulance if a medical emergency should arise. I accept full responsibility for all medical/dental expenses that may be incurred as a result of my participation in this program.

Signature

Date