



ST PATRICK'S CATHOLIC CHURCH

**SUMMER
REACH OUT
MIDDLE SCHOOL
MISSION WEEK**

All Youth Grades 6-8

July 28-30, 2020

**ARE YOU INTERESTED?
COMPLETE THE ATTACHED FORM TO REGISTER**

**DO YOU HAVE QUESTIONS
ABOUT SUMMER REACH OUT?
CONTACT ROB MASLOSKI
RMASLOSKI@ST-PATRICKS.ORG**

Summer Reach Out Info:

- Reach Out is for all youth in 6-8 grade during the 2019/20 school year
- Youth in grade 9-12 and adults 18+ are encouraged to join us as leaders (contact Rob to join the leadership team)
- Each Day consists of service work at a variety of local non-profits and fun afternoon activities
- Cost: \$50 includes transportation, lunch, t-shirt



**SUMMER REACH OUT IS
AN EVENT OF IGNITE
MIDDLE SCHOOL
YOUTH GROUP
AT ST PATRICK
CHURCH**

Summer Reach Out
PARENTAL CONSENT FORM & INDEMNITY AGREEMENT
For Day Trips

Student/Participant Name _____

Date of Birth _____ Gender _____

Parent/Guardian Name _____

Home Address _____

Home Phone _____ Business Phone _____

Parish/School _____

Date of Event/Field Trip 7/28-30/2020 Type of Field Trip Middle School Mission Trip

Destination Local Service Sites and Afternoon activities Cost \$50

Individual(s)/Teacher(s) in Charge Rob Masloski

Transportation and Arrival: School Bus

I, _____, grant permission for _____
Parent or Guardian Name Child Name

to participate in the above named activity and I warrant that my child is in good health. In consideration of my child's participation, I agree to indemnify the St Patrick Catholic Church and the Archdiocese of Saint Paul and Minneapolis from any claims or law suits brought against St Patrick Catholic Church /Archdiocese of Saint Paul and Minneapolis by myself, my child or others, that arises out of any behavior by my child at the event/activity described above. I also agree to pay reasonable attorney's fees or expenses incurred by the parish/school and the Archdiocese in defense of such a claim/suit.

EMERGENCY MEDICAL TREATMENT: In the event of an emergency, I give permission to transport my child to a hospital for medical treatment. I wish to be advised prior to any further treatment by a doctor or hospital. In the event of any emergency, if you are unable to reach me at the above numbers, contact

Name Phone Number

MEDICAL INFORMATION:

Medication my child is taking at present _____

Allergies _____

Other Medical Conditions _____

Family Health Plan carrier number _____

Family Doctor _____ Phone Number _____

As Parent or Guardian, I agree to all of the above stated considerations and conditions.

Signature Date