☐ **Mens Fall Retreat Date:**
Nov. 16 - Nov. 19, 2023
Director: Deacon Bill Roche
(318) 402-8406
billr7850@gmail.com

ACTS RETREAT REGISTRATION

☐ **Ladies Fall Retreat Date:**
Nov. 9 - Nov. 12, 2023
Director: Rachel Feducia
(318) 455-5548
rachel.l.c.feducia@gmail.com

ACTS is a retreat ministry offering three-day Catholic retreats for men and women, ages 18 and over, led by a priest and lay members of several local parishes. The goal of the retreat is to help you deepen your relationship with Jesus Christ, receive spiritual renewal, give new meaning to Sunday liturgy and your prayer life, and build lasting relationships with members of our community.

***LOCATION*:** Round trip transportation from **St. Joseph Catholic Church** (204 Patton Ave., Shreveport) to **Camp Bethany** retreat center is provided for all retreatants. Send-off is in the **St. Joseph Narthex** (foyer) on **Thursday evening. Plan to be there to check-in between 5:30 – 5:45pm**. The retreat ends on Sunday following the 12:30pm Mass at St. Joseph, followed by a reception in the Family Life Center.

COST: The total cost is **$200.00**. A **deposit** of **$75.00** must be submitted with this form in order to reserve your place. The remaining **$125.00** is due Thursday at Send-off. Please make your checks payable to **St. Joseph Catholic Church.** There will be a $25 fee for returned checks. If a retreat date becomes full or if you need to back out, your deposit will be returned to you.

FINANCIAL SCHOLARSHIP: Financial difficulties should not prevent anyone from attending. If you are unable to pay all or part of the fee, confidential financial arrangements can be made by notifying the retreat Director or answering Question 18.

***MAILING ADDRESS*:** Mail (1) ACTS Retreat Registration form, (2) Hold Harmless Agreement, (3) Emergency Medical Authorization, and (4) check to **St. Joseph Catholic Church, Attn: ACTS, 211 Atlantic Ave., Shreveport, LA 71105**. You will be notified when ALL forms and check have been received. Contact the Director if you are not notified within 3 weeks of mailing.

Please Print Clearly

1. Name: _____ 2. Male / Female (circle one) 3. T-Shirt Size: S M L XL 2XL 3XL (circle one)
4. First and last name as you want it to appear on your Name Tag: _____
5. Full Address: _____
6. Cell Phone: _____ 7. Home Phone: _____
8. Email: _____ 9. Date of Birth: _____ (must be 18 years old at the time of the retreat)
10. Three Emergency Contacts:

Name	Relationship	Cell Phone	Email

11. Do you need assistance climbing stairs? Yes / No 12. Do you have trouble walking? Yes / No
13. List special dietary or medical needs, if any: _____
14. What church do you attend? _____ (Name) (City)
15. Are you Catholic? Yes / No
16. Do you give permission for your photo and contact information to be added to the retreat directory? Yes / No
17. Do you give permission to receive future ACTS communications via email? Yes / No
18. Check One:
____ I have included my deposit of $75.00 (Payable to St. Joseph Catholic Church), or
____ I have included the entire fee of $200.00, or
____ I need scholarship help (someone will contact you)

For Internal Use Only
Date received _____

HOLD HARMLESS AGREEMENT

To the fullest extent permitted by law, _____ releases and
(Participant)
agrees to defend, pay on behalf of, indemnify, and hold harmless Bishop Malone, the Diocese of Shreveport and St. Joseph Catholic Church (collectively, the "Sponsor"), its elected and appointed officials, its agents, employees and volunteers and others working on behalf of the Sponsor against any and all claims, demands, suits, or loss, including attorney's fees and all costs connected therewith, and for any damages which may be asserted, claimed or recovered against or from the Sponsor, its elected and appointed officials, its agents, employees, volunteers, or others working on behalf of the Sponsor, by reason of personal injury, including bodily injury or death and/or property damages, including loss of use thereof, suffered by Participant.

Participant Signature: _____

Date: _____

WITNESS 1:

Printed Name: _____

Signature: _____

Date: _____

WITNESS 2:

Printed Name: _____

Signature: _____

Date: _____

ST. JOSEPH CHURCH
EMERGENCY MEDICAL AUTHORIZATION

PURPOSE*: To enable participants to authorize emergency treatment should they become ill or injured while participating in church-sponsored event.*

Name of Participant: _____

Social Security Number: _____ Main Phone Number: _____

Full Address: _____

*** * * PLEASE ANSWER BOTH QUESTIONS * * ***

1. Do you grant consent for treatment in the event of an emergency?

❑ YES, I GRANT CONSENT TO TREAT

In the event of an emergency, contact will be made in the following order:

A. A reasonable attempt will first be made to contact the following designated individuals:

Emergency Contact 1: _____ Relation: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____

Emergency Contact 2: _____ Relation: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____

B. If unsuccessful in contacting the above persons, I hereby give my consent for administration of any treatment deemed necessary by:

Preferred Physician: _____ Office Phone: _____

Physician #2: _____ Office Phone: _____

C. In the event the designated preferred practitioner is not available, I give consent to be treated by another licensed physician or dentist; and/or to be transferred to either ❑ **Nearest Hospital reasonably accessible** or ❑ **Preferred Hospital** _____.

- This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring the necessity for such surgery, are obtained before surgery is performed.
- I, the undersigned, understand that participation in activities inherently involve risk, including injury. As such, I hereby release, waive, discharge, and covenant not to sue from any loss, damage, or injury, including death, that may be sustained by myself, whether caused by negligence while participating in such activity where the activity is being conducted.
- Facts concerning my medical history including allergies, medications being taken, and any physical impairments to which a physician should be alerted are listed below in Question 2.

Signature: _____ ***Date***: _____

❑ NO, I REFUSE CONSENT TO TREAT

I do not give my consent for emergency treatment of myself. In the event of illness or injury requiring emergency treatment, I wish the church authorities to take no action or to: _____
_____

Signature: _____ ***Date***: _____

2. Do you have medical conditions or take medications? ❑ Yes ❑ No

Medical conditions (i.e. diabetes, bee sting allergy): _____
_____
_____

Medications: _____
_____
_____

Drug allergies: _____
_____