Men's Spring Retreat

April 28 - May 1, 2022

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RETREAT REGISTRATION

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 the retreat center in Minden is provided for all retreatants. Sendoff is at the **St. Joseph Family Life Center** on **Thursday evening at 5:00pm**. The retreat ends on Sunday following the 12:30pm Mass at St. Joseph Catholic Church, followed by a reception at the Family Life Center.

COST: The cost of the retreat (room and board) is **$200.00**. Your **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.** Post-dated checks will not be accepted and all checks will be processed and deposited upon receipt. We will not hold checks. There will be a $25 fee for all returned checks. If a retreat date becomes full, your deposit will be returned to you.

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

***MAILING ADDRESS*:** Mail (1) Retreat Registration Form, (2) Hold Harmless Agreement, (3) Emergency Medical Authorization, and (4) $75.00 deposit check to **NWLA ACTS, P.O. BOX 52761, SHREVEPORT, LA 71135**. These forms can only be accepted by mail, as each form is numbered as it is received. Registration is not complete until all forms are filled out completely. You will be notified by ACTS 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. T-Shirt Size: (circle one) S M L XL 2XL 3XL

3. First and Last Name as you want it to appear on your Name Tag: ______________________________

4. Full Address: ______________________________

5. Home Phone: ______________ 6. Cell Phone: ______________ 7. Work Phone: ______________

8. Email: ______________________________ 9. Date of Birth: ______________
(must be 18 years of age at the time of the retreat)

10. Three Emergency Contacts:

Name	Relationship	Cell Phone	Email

11. Do you have trouble climbing stairs? Yes / No (circle one) 12. Do you have trouble walking? Yes / No (circle one)

13. List special dietary or medical needs, if any: ______________________________

14. What church do you attend? ______________________________
Name City

15. 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 have included partial payment with scholarship need

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 stings): ____
____
____

Medications: ____
____
____

Drug allergies: ____
____