

Central Valley Acolyte Retreat

November 15th, 3 pm Saint Basil's Church, Stockton



Come for an afternoon of fun, fellowship, and faith with Greek Orthodox altar boys ages 10-18 from parishes of California's Central Valley!!

Schedule: Sunday, November 15th, 2009

3:00- Opening Remarks, Deacon Niko Bekris

3:15- Altar Boy Olympics

4:15- Speaker #1- Father Jon Magoulias

4:45- Organized Games

4:45- Confessions (optional)

5:45- Speaker #2- TBD

6:15- Dinner

7:00- Vespers

7:30- Group Picture

Contact: Deacon Niko Bekris, Director, Youth and Young Adult Ministries,

Metropolis of San Francisco: sfyouth@sanfran.goarch.org



2009 METROPOLIS OF SAN FRANCISCO
ACOLYTE RETREAT- CENTRAL VALLEY

REGISTRATION FORM

NOVEMBER 15TH, SAINT BASIL GREEK ORTHODOX CHURCH, STOCKTON

Participant Information:

LAST NAME: _____ FIRST NAME: _____

ADDRESS: _____

CITY: _____ STATE _____ ZIP CODE _____

PHONE: _____ E-MAIL: _____

DATE OF BIRTH: ____/____/____

YEARS SERVING IN ALTAR: _____ PARISH/PRIEST: _____

PARENTS NAMES OR LEGAL GUARDIANS: _____

INSURANCE CARRIER: _____ POLICY NUMBER: _____

DIETARY RESTRICTIONS: _____

Please send Registration by NOVEMBER 9th to:

St. Basil Greek Orthodox Church
Attn: Central Valley Acolyte Retreat
920 W March Lane
Stockton, CA 95207

Activities Information:

Is your child limited to any activity? (if yes, please explain) _____

Health Information:

MEDICAL INSURANCE: _____ POLICY NO. _____

PRIMIARY CARE PHYSICIAN _____ PHONE: _____

Does the participant have any allergies? (Circle One) YES NO

List any food allergies: _____

List any environmental allergies: _____

List any medication allergies: _____

List any medications your child is currently prescribed: _____

(Please use another sheet to explain any and all conditions, illnesses, or special needs your child has.)

(PLEASE FILL OUT SECOND PAGE)

Emergency Information:

EMERGENCY CONTACT #1: _____ RELATION: _____

HOME NO: _____ WORK: _____ CELL: _____

EMERGENCY CONTACT #2 _____ RELATION: _____

HOME NO: _____ WORK: _____ CELL: _____

Pick-up/Drop-off Information:

WHO WILL BRING YOUR CHILD TO THE RETREAT? _____

WHO WILL PICK YOUR CHILD UP FROM THE RETREAT? _____

RELATION TO CHILD: _____

If you have any questions, please contact Deacon Niko Bekris at:

(415) 814-1186 (office)

(415) 753-1165 (fax)

(PLEASE FILL OUT THIRD PAGE)

GREEK ORTHODOX METROPOLIS OF SAN FRANCISCO

ACOLYTE RETREAT

Saint Basil Greek Orthodox Church, Stockton, November 15, 2009

AUTHORIZATION FOR CONSENT FOR TREATMENT OF A MINOR AND LIABILITY WAIVER FORM

I the parent or legal guardian hereby authorize and consent to X-ray examination, or any other examination by licensed personnel on the staff of any licensed hospital. This authorization is given in advance of any specific diagnosis; treatment of hospital care required but is given to provide authority and power to render care, which is deemed advisable in the best judgment of the physician. It is understood that an effort will be made to contact the undersigned prior to rendering treatment, but that any accepted medical treatments will not be withheld if the undersigned cannot be reached. In recognition of the possible dangers to my child, I hereby knowingly and voluntarily waive any right or cause of action of any kind against the members, directors, agents, employees of the Greek Orthodox Archdiocese of America, the Greek Orthodox Metropolis of San Francisco, Saint Basil Greek Orthodox Church or my local parish for any personal injury that may occur at or during the retreat. Nor shall they be liable for any personal injury to my child occurring during the transportation to and from the retreat. I hereby understand that any medical expenses that my child may incur due to personal injury or illness is my financial responsibility and not that of the Greek Orthodox Archdiocese of America, the Greek Orthodox Metropolis of San Francisco, or Saint Basil Greek Orthodox Church or my local parish.

SIGNATURE OF PARENT OR GUARDIAN

DATE