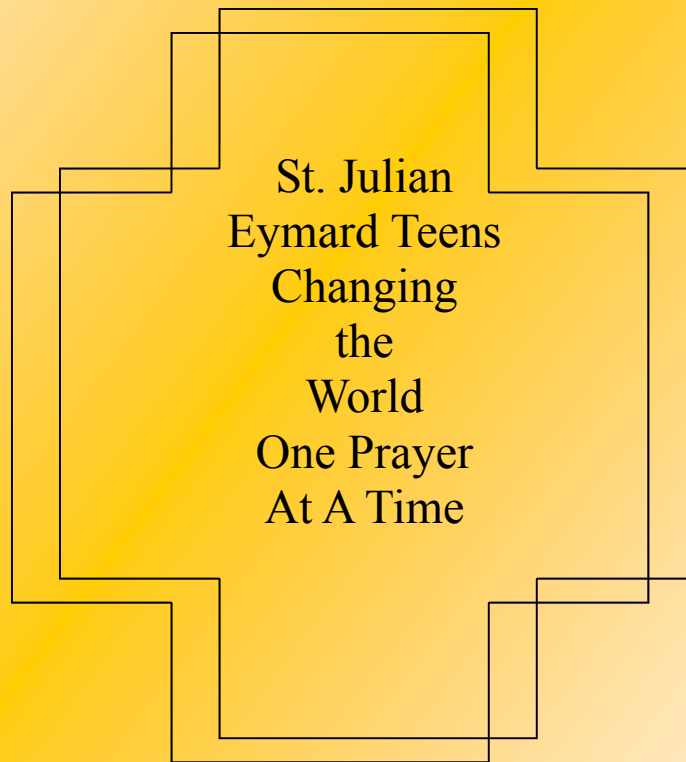


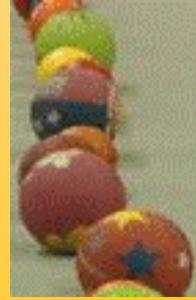
St. Julian Eymard High School Youth Ministry



St. Julian Eymard Teens
Candidates for the Sacrament of Confirmation
Sophomores/Juniors/Seniors



LIVE MUSIC



DODGE BALL

FIRE UP FOR 2011!

Saturday

August 28, 2010

6:30 - 10:00 P.M.

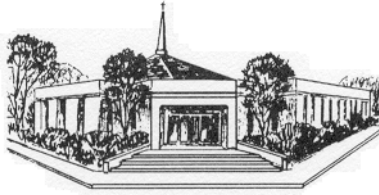
St. Julian Eymard



HOT OFF THE
GRILL
SIZZLIN'
BURGERS AND
DOGS. . . SMORES
AND MORE!



LET US KNOW YOU ARE COMING!
SIGN UP
IN THE VESTIBULE OF THE CHURCH
OR EMAIL:
GCARLSON@STJULIANEYMARD.COM
OR CALL MR. SWAN @ 847-524-8657



SAINT JULIAN EYMARD SCHOOL OF RELIGION
601 Biesterfield Road • Elk Grove Village, Illinois 60007

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CHURCH TELEPHONE (847) 956-0130 • SCHOOL OF RELIGION TELEPHONE (847) 593-8938
FAX (847) 956-0189 • WEBSITE: www.stjulianeynard.com

Special Event Permission Form

I/We, the parent(s) of _____ request that the St. Julian Eymard School of Religion allow my(our) child to participate in the Youth Ministry Event: **Outdoor Game Night, Cookout and Campfire**, held on Saturday, August 28th, 2010 at St. Julian Eymard Catholic Church, 601 W. Biesterfield Road, Elk Grove Village, Illinois from 6:30pm until 10:30pm. The games planned for the evening include **dodgeball, basketball, softball, baggo**, and **bocce ball**.

I hereby release and indemnify St. Julian Eymard Catholic Church, its staff and its volunteers, and the Catholic Bishop of Chicago, a corporation sole, from any and all liability arising from claims of any kind or nature whatsoever from my child's participation in this event.

Authorization for Medical Treatment (2010)

In the event that the undersigned, or my (our) authorized physician, cannot be reached, and in the judgment of Mrs. Therese Bergmann, (the Director of Religious Education or other responsible person accompanying the group) or other appropriate staff member, there is a necessity for immediate examination and/or treatment of my (our) child, I hereby authorize any of the aforesaid personnel to obtain for my child such medical services as are deemed necessary.

Name of Child _____

Medical Allergies/Significant Medical History _____

Name of Physician _____ Phone# _____

Address _____

Medical Insurance Company _____ Insurance Number _____

Other Contact in case of emergency:

Name _____ Phone# _____

Relationship _____

Parent's Name: _____

Address: _____

Phone #: _____

Parent Signature

Date