For Office Use Only:
Date Received: _____
Ck Amt: _____
Ck #: _____
Amount Due: _____

Saint Basil Salvatorian Center
30 East Street, Methuen, MA 01844
978 683-2959
www.saintbasils.org

www.tee

Teen Encounter

Month/Year of Weekend ***Request***

Name: _____ Age: _____ Sex: _____

Name for Name Tag: _____ Date of Birth: _____

Address: _____ Telephone: _____

City: _____ State: _____ Zip: _____

E-mail _____

Parish/Pastor/Church Address: _____

Have you been Baptized? _____ Have you made an encounter before: _____

Where? _____ When? _____ How Many? _____

Requirements:

- Applicant must be in high school (or graduated) and willing to comply with the rules of the house.
- Check-in is at 7:30 pm on Friday & estimated time of departure is 6:30 p.m. on Sunday.
- Dress for the weekend should be proper for a Christian gathering.
- Drugs and alcohol are not permitted.
- *Peanuts & any food containing peanuts are not allowed due to chance of severe allergic reaction*.
- Teens cannot commute & must be present the entire weekend.
- Applicants who have not made an Encounter have first preference.

Fee: The cost of the weekend is $75, which includes a non-refundable processing fee of $25 that must accompany this application. The retreat fee covers 2 nights lodging and 5 complete meals starting Saturday morning. *Make checks payable to:* ***Saint Basil Salvatorian Center*** *and mail applications to:* ***30 East Street, Methuen, MA 01844***

Specified Medical Information & Release Form (complete both sides)

The Salvatorian Center will take reasonable care to see that the following information will be held in confidence.

Allergic reactions (medications, foods, plants, insects, etc.) _____

Immunizations: Date of last tetanus/diphtheria immunization: _____

Does child have a medically prescribed diet? _____

Any physical limitations? _____

Is child subject to chronic homesickness, emotional reactions to new situations, sleepwalking, bedwetting, fainting? _____

Has child recently been exposed to a contagious disease or conditions, such as mumps, measles, chickenpox, etc.? If so, date and disease or condition: _____

You should be aware of these special medical conditions of my child:_____

_____

(Continued on Other Side)

Parent/Guardian Medical Release Form

Parent/Guardian Name: _____

Home Address: _____

Home Phone: _____ Business or Cell Phone: _____

Of the following statements pertaining to medical matters, sign only those in accordance with your wishes:

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

Name & Relationship: _____

Home Phone: _____ Business or Cell Phone: _____

Family Doctor: _____ Phone: _____

Family Health Plan Carrier: _____ Policy Number: _____

Parent/Guardian Signature: _____ Date: _____

OTHER MEDICAL TREATMENT: In the event it comes to the attention of the Center that my child becomes ill with symptoms such as headache, vomiting, sore throat, fever, diarrhea, I want to be called.

Parent/Guardian Signature: _____Date: _____

MEDICATIONS: CHOOSE ONE OF THE BELOW LISTINGS (A OR B)

A) No medication of any type whether prescription or nonprescription may be administered to my child unless the situation if life-threatening and emergency treatment is required.

A) ***Parent/Guardian Signature***: _____ Date: _____

B) I hereby grant permission for nonprescription medication (such as aspirin, throat lozenges, cough syrup) to be given to my child, if deemed advisable.

B) ***Parent/Guardian Signature***: _____ Date: _____

TEEN APPLICANT'S SIGNATURE: _____

PARENT/GUARDIAN SIGNATURE: _____

The Salvatorian Center is a Drug, Alcohol and Tobacco Free Facility.