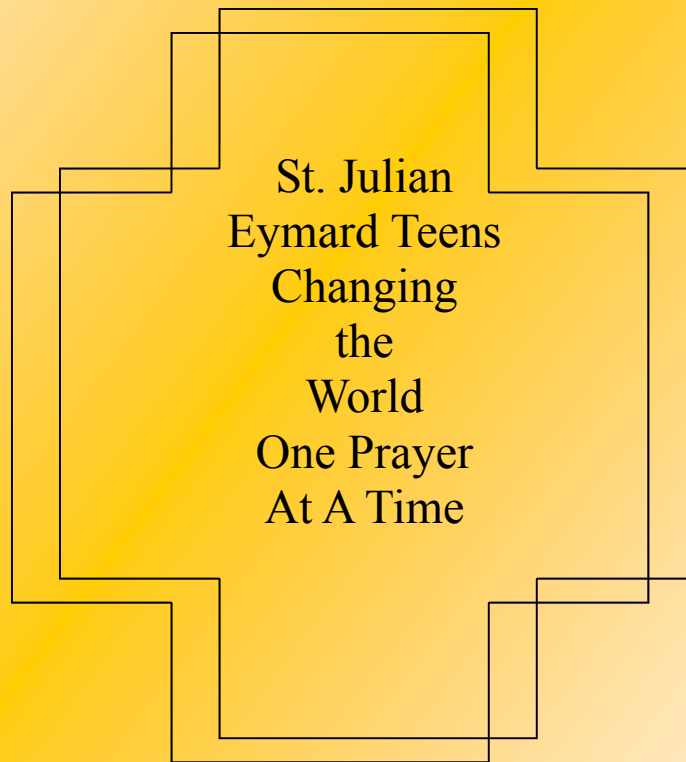


St. Julian Eymard High School Youth Ministry



IT'S SPLASHTASTIC!

Hey Teens!

How about a day at the water park?

Not just any water park!



In Rockford!

Ride the famous water coaster or one of the many water slides.



Who: Any Teen 13 and older!

When: Saturday July 24th.

Time: 10:00am—5:30pm

Your day of fun begins with a bus ride to Magic Waters. It includes admission, snacks and refreshments!

How Much? \$25.00

Bring some money for lunch and munchies!

Sign Up Soon and Bring A Friend!!

To Sign Up Call Mr. Swan
847-524-8657

or Mrs. Carlson

847-593-8938

See Attached Permission Slip

**Join the fun in July and
Fire Up for 2011
on August 28, 2010!**



Sponsored By St. Julian's High School Youth Group!



ST. 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

Magic Waters Permission Form

I/We, the parent(s) of _____ request that the St. Julian Eymard School of Religion allow my (our) child to participate in going to Magic Waters, 7820 CherryVale N Blvd, Cherry Valley, IL 61016-9989, IL, on Saturday, July 24, 2010. We will be leaving from St. Julian Church at 10:00 a.m. and arriving back at St. Julian Church at approximately 5:30 p.m.

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