

ST. MARGARET MARY PARISH— LINC HIGH SCHOOL YOUTH MINISTRY

Knott's Scary Farm Night



39th Annual
Halloween Haunt
2011

**SATURDAY, OCTOBER 15, 2011
5PM-3AM**

Cost is Only \$50

Arrive at St. Margaret Mary Youth Office by 5PM,
Return Time to St. Margaret Mary: 3am (October 16th)
No Costumes—Friends are welcome!

TO REGISTER: Turn in Knott's Scary Farm Night Permission Slip to the Front Desk or Youth Office by Sunday, October 2, 2011.

We need Adult Chaperones and drivers!



**ST. MARGARET MARY PARISH
HIGH SCHOOL YOUTH MINISTRY
25511 ESHELMAN AVE,
LOMITA, CA 90717
310-326-3364 EXT 17**

KNOTT'S SCARY FARM REGISTRATION

Name: _____

Address: _____

City: _____ Zip: _____

Home Phone: _____

Youth's Cell: _____

Father's Cell Phone: _____

Mother's Cell Phone: _____

Email: _____

This registration form, the complete Knott's Scary Farm Permission Slip (See Reverse) and the \$50 Registration fee needs to be submitted to the youth office or parish front desk by Sunday, October 2, 2011. Make checks payable to St. Margaret Mary Parish with Knott's Scary Farm in the memo line.

Departure Time From St. Margaret Mary: 5pm

Return Time to St. Margaret Mary: 3am (October 16th)

**ST. MARGARET MARY PARISH
KNOTTS SCARY FARM NIGHT
PERMISSION/MEDICAL RELEASE FORM**

(not needed for 18 years or older)

_____ in _____ has my permission to attend St. Margaret Mary's Knott's Scary
Youth's Name **Grade**
Night in Buena Park, California on October 15, 2011 from 5pm-3am. The undersigned authorizes the Adult Leaders
of St. Margaret Mary's Youth Ministry Program to provide and authorize medical treatment for
_____ during the above-referenced time period. The undersigned hereby agrees to
Youth's Name
release the St. Margaret Mary's Youth Ministry Program Leaders of any and all liability, responsibility and damages
whatsoever including but not limited to accidents, personal and mental injury, illness and death that may occur dur-
ing the above-referenced time period.

EMERGENCY MEDICAL INFORMATION

Parent's Name: _____ Phone #: _____

Address: _____ Work #: _____

Parent's Cell # _____ Policy ID# _____

Insurance Carrier: _____ Policy #: _____

Carriers Address: _____

Family Doctor: _____ Phone #: _____

List any medications this child takes on a regular or daily basis: _____

Special Medical Instructions - include any known allergies: Please Attach

In case Parent cannot be reached, please contact:

Name	Relationship	Phone
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I, the undersigned, hereby agreed with the above-referenced participation in the Religious Education Program, Release and Medical Au-
thorization.

Dated	Signature of Parent/Legal Guardian	Print Name of Parent/Legal Guardian
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