

### Event Information

**WHAT:** "Sandwich Run";

**WHEN:** February 20, 2010 - 10:00AM - 3:30 PM

**WHERE:** People's Park at UC Berkeley; 2556 Haste St., Berkeley CA, 94704

**WHY:** Serving the Socio-Economically Disadvantaged; delivering lunch to the homeless

**CONTACTS (c):** Rosemary Hua (408) 834-0236, Derek Bau (408) 781-5551, Alan Hsia (408) 892-6314

**We will be meeting at St. Clare's parking lot to carpool to People's Park at 10:00 AM. Please be prompt!**

### Participant Information

PARTICIPANT'S NAME: \_\_\_\_\_ EMAIL: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ PHONE: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

PARISH: ST. CLARE'S PARISH BIRTHDATE: \_\_\_\_\_ GRADE: \_\_\_\_\_ GENDER: \_\_\_\_\_

PARENT/GUARDIANS' NAME: \_\_\_\_\_ HOME PHONE: \_\_\_\_\_

PARENT EMAIL: \_\_\_\_\_ WORK/CELL PHONE: \_\_\_\_\_

DOCTOR'S NAME: \_\_\_\_\_ DOCTOR'S PHONE: \_\_\_\_\_

INSURANCE COMPANY: \_\_\_\_\_ POLICY #: \_\_\_\_\_

Are there any known allergies to food or medications that those who work with your young person should be aware of? **YES** **NO**

If YES, explain: \_\_\_\_\_

Are there any known physical, psychological, or emotional limitations that would affect this young person's participation in this event? **YES** **NO**

If YES, explain: \_\_\_\_\_

EMERGENCY CONTACT IN THE EVENT THE PARENT(S) CANNOT BE NOTIFIED:

NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

### Release Form

I request that the San Jose Chinese Catholic Community, Watermark Youth Group, permit my child to participate in the Sandwich Run to be held from February 20, 2010 - 10:00-3:30 at People's Park 2556 Haste St. Berkeley, CA, 94704. I understand that reasonable precautions will be taken to safeguard the health and well being of my child, and that I will be notified as soon as possible in the event of an emergency. In case of sickness or accident, I authorize and consent to any x-ray exam, anesthetic, medical, dental or treatment and hospital care to be rendered to my child under the general care and advice of any physician, dentist or surgeon licensed to practice in any state. I further understand and agree to be responsible for any such medical, dental and/or hospital expenses incurred.

PARENT'S

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_