Teen ACTS Retreat
August 1 - August 4, 2024

Jesus said to them, "I am the bread of life; whoever comes to me will never hunger, and whoever believes in me will never thirst." John 6:35

ACTS is an acronym for Adoration, Community, Theology, and Service. The goals of an ACTS retreat are to strengthen our faith and its application in our daily lives, to discover or renew ourselves spiritually, and to build lasting friendships. Teens present the retreat with spiritual direction from the clergy and help from lay adults. This is a Catholic retreat but all Christian teens entering the 10th grade through graduating 12th grade are welcome to attend. If you do not meet the grade requirements, you still may be eligible by contacting the director below.

The retreat begins Thursday evening, August 1, with check-in from **5:15 - 5:45 PM** at St. William of York Catholic Church in Tewksbury, MA. Transportation will be provided to La Salette Retreat and Conference Center located in Attleboro, MA. We will return to St. William of York Catholic Church on Sunday, August 4, for the 11:30 AM Mass. A welcome home reception will follow. The total cost of the retreat is $250 and includes lodging, food, and many activities. A deposit of $50 made payable to "St. William ACTS" must accompany this form to reserve your place. The remaining balance of $200 will be due at the Thursday evening check-in. **Please Note:** Financial difficulties should not prevent anyone from attending the retreat. If you have concerns, please contact the director below. Approximately 7-10 days prior to the Retreat, you will receive a letter describing the necessities you should bring with you. Please call any of the contacts listed below if you need further information or have any questions. We greatly look forward to having you with us!

Please send your completed registration form and deposit to:

St. William of York Teen ACTS Retreat
Attn: Rebecca Keenan
1351 Main St
Tewksbury, MA 01876

Questions and inquiries please contact:

Rebecca Keenan
Adult Director
978-989-2068

Diego Monteiro
Teen Director
978-770-5902

Jimmy Coppinger
Adult Co-Director
603-475-0138

Norah Smith
Teen Co-Director
978-606-8072

Please return this section with your deposit for the Teen ACTS Retreat.

Name:_______________________________________ M-F________
Name as you want it on name tag:____________________________
Address:____
City:____________________________________ State: _________ Zip:______________
Date of Birth:______________________________
Home Phone:________________________ Cell Phone: ______________________
Email:____
Parish:______________________________ City: __________________ State: __________
Emergency Contact: ______________________________________Relationship: _______________
Phone:_______________________

*If you are under 18 years of age, a parent or guardian must fill out the permission form attached to this application.

Teen ACTS Retreat

August 1-4, 2024
St. William (Tewksbury), St. John/St. Thomas (Peabody), and Holy Rood Collaborative (Chelmsford)

TEEN'S NAME________________________________ AGE: ______ BIRTH DATE: __________
ADDRESS:________________________ CITY_________________ STATE____ ZIP________
ALLERGY/SPECIAL DIETARY NEEDS: ________________________ MEDICATIONS: _______________

PARENT/GUARDIAN NAME: ____________________________
ADDRESS:________________________ CITY_________________ STATE____ ZIP________
HOME PHONE: ____________________ CELL PHONE: _____________________
EMAIL ADDRESS: ____

I,________________________________, grant permission for my child, __________________________________ to participate in this parish youth ministry event that requires transportation to a location away from the parish site. This activity will take place under the guidance and direction of the Youth Ministers and parish volunteers from St. Williams, Tewksbury, St. John/St. Thomas, Peabody Catholic Churches, and Holy Rood Collaborative, Chelmsford.
In case of an accident, we (I) authorize an adult, in whose care the minor has been entrusted, to consent to any x-ray examination, anesthetic, medical, surgical, or dental diagnosis or treatment, and hospital care, to be rendered to the minor under the general or special supervision and on the advice of any physician or dentist licensed under the provisions of the Medical Practice Act on the medical staff of a licensed hospital, whether such diagnosis or treatment is rendered at the office of said physician or said hospital.

I (we) will be liable and agree to pay all costs and expenses incurred in connection with such medical and dental services rendered to our (my) child pursuant to this authorization.

______________________________________ ______________________________________

PARENT/GUARDIAN NAME (printed) PARENT/GUARDIAN NAME (signature)

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Date