

Diocese of Dallas Medical Release and Liability Waiver Form

Participant's Name: _____ Sex: (circle one) M F Birth Date: _____ Age _____

Parent/Guardian Name: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (____) _____ Business Phone: (____) _____

Parish Name & City: _____ Graduation year: 03 04 05 06 07 ADULT

E-mail: _____

ADULTS ONLY - This box - ADULTS ONLY
Medical Release/Information

I agree on behalf of myself, my heirs, successors, and assign to hold harmless the Diocese of Dallas, the youth ministry program, their officers, directors, and agents from any liability for illness, injury or death arising from or in connection with my attending the _____
_____. I understand that this is an event sponsored by the Diocesan youth ministry office and that it is presented by and through the Dioceses of Dallas.

In the event any legal action is taken by either party against the other party to enforce any of the terms and conditions of this agreement, it is agreed that the unsuccessful party to such action shall pay to the prevailing party therein all court costs, reasonable attorneys fees and expenses incurred by the prevailing party.

In the event that I should require medical treatment and I am not able to communicate my desires to attending physicians or other medical personnel, I give permission for the necessary emergency treatment to be administered. Please advise the doctors that I have the following allergies:

In case of an emergency and for permission for treatment beyond emergency procedures, please contact:

Name: _____ Relationship to me: _____

Day Time Phone Numbers: _____ Night Time Phone Number: _____

Insurance Carrier: _____

Insurance Policy Number: _____ Insurance ID Number: _____

Signature

Date

YOUTH The rest of the form is for: YOUTH
Parent/Guardian/Conservator Permission and Liability Waiver

I, _____ grant my permission for my son/daughter, _____
Parent/Guardian/Conservator signature *Participant's Name*

to participate in the _____. I understand that this is an event sponsored by the Diocesan youth ministry office and that it is presented by and through the Diocese of Dallas.

I understand that as parent/legal guardian, I remain legally responsible for any personal actions taken by my son/daughter named above.

I agree on behalf of myself, my son/daughter named herein, our heirs, successors, and assigns to hold harmless, the Diocese of Dallas and its employees and/or volunteers from any and all claims for illness, injury, death and the cost of medical treatment therewith, arising from or in any way connected with my son's/daughter's attending the _____ during the dates named above.

In the event any legal action is taken by either party against the other party to enforce any of the terms and conditions of this agreement, it is agreed that the unsuccessful party to such action shall pay to the prevailing party therein all reasonable court costs, reasonable attorneys' fees and expenses incurred by the prevailing party.

_____ *Date*

Parent/Guardian/Conservator signature

If you are unable to reach me, please contact: _____ Relationship to my child: _____

Home Phone:(____) _____ Business Phone:(____) _____

Please fill out the information below OR attach a photocopy of your (child's) insurance card front and back.

Insurance Carrier: _____

Policy Number: _____ Insurance ID Number: _____

To the best of my knowledge, my child _____, is in good health, and I assume all responsibility for the health of my child. In the event of a medical emergency, I give permission to transport my child/for my child to be transported to a hospital for emergency medical or surgical treatment. I wish to be advised prior to any further treatment by the hospital or doctor.

Parent/Guardian/Conservator signature Date

Sign only those statements in section 1 - 4 which are true and in accordance with your wishes.

Medications:

1. My child takes no medication and will bring no medication with him/her.

Parent/Guardian/Conservator signature Date

2. My child takes medication/s and will self-medicate. My child will bring all such medications necessary, and such medications will be clearly labeled. I understand that my child will be required to turn all medication(s) over to a supervising adult designated to keep medication(s). I further understand that it will be my child's responsibility to present himself/herself at a location designated for returning medication(s) to my child at the frequencies/times listed below. I understand that the adult to whom my child surrenders the medication has no medical training and this adult will not measure dosages. My child will return the medication(s) to the adult after he/she self-medicates. At the conclusion of the event it will be my child's responsibility to pick up remaining medication(s), if any, at the self medication designated location. Names of medications and exact dosage and frequencies/times are as listed below:

Parent/Guardian/Conservator signature Date

3. My child takes medication but is unable to self-medicate. The child's parent/guardian will provide and dispense any and all needed medications.

Parent/Guardian/Conservator signature Date

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

Parent/Guardian/Conservator signature Date

4 b. I grant permission for the following non-prescription medication to be given to my child **(EXCLUDING MEDICATIONS NAMED BELOW THAT MAY CAUSE ALLERGIC REACTION).**

Non-aspirin pain reliever Yes ___ No ___ # of tablets per dosage _____. Throat Lozenge Yes ___ No ___ Antacid Yes ___ No ___

Decongestant Yes ___ No ___ # of tablets per dosage _____. Antihistamine Yes ___ No ___ #of tablets per dosage _____.

Specific Medical Information for (circle one) Self or Child

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

Immunizations: date of last tetanus/diphtheria immunization

Medications child currently takes

Any physical limitations

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

Has your child recently been exposed to contagious disease or condition such as mumps, measles, chicken pox, etc.? If so, date and disease or condition.

You should also be aware of these special medical conditions of my child. *Please attach a clear description to this form*

Signature of Parent/Guardian/Conservator: _____