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Name (of child): _____

Age ____ Date of Birth ____ / ____ / ____ Home Phone _____

Address _____ City _____ Zip _____

Father / work phone: (____) _____

Mother / work phone: (____) _____

Medical Information:

Does your child have a medical or psychological condition that we should be aware of? ____ Yes ____ No

If yes, please explain: _____

Does your child have a medical or psychological problem that requires prescribed medication to be taken at specific times? ____ Yes ____ No

If yes, please explain: _____

Any other information you deem necessary: _____

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Name nearest relative not living with above named youth:

Name: _____ Relationship _____

Address _____ City _____ Zip _____

Home phone: (____) _____ Work phone: (____) _____

I hereby release and discharge **Annunciation Church** and each and all of their agents and employees from any liability whatever resulting from or in any manner arising out of injury or damage which may be sustained on account of my child's participation in activities associated with **Religious Education Program**, both on and off site activities, or the transportation in connection therewith.

The undersigned hereby authorized the **Religious Education Staff** or representative to obtain such medical aid or assistance as might be required for immediate care of my child in the event of an emergency. This permission will include the administration of medicines, anesthetic or surgical treatment, X-ray examinations, or hospitalizations such as might be ordered by a duly licensed medical doctor or dentist. In no event will **Religious Education Staff**, the parish, and its representatives, be held liable for any first aid rendered or treatment performed pursuant to this consent.

It is understood that this authorization is given in advance of any specific consent to any and all such diagnosis, treatment, or hospital care being required but is given to provide authority and power on the part of **Religious Education Staff** to give specific consent to any and all such diagnosis, treatment, or hospital care which the aforementioned persons in exercise of their best judgment may deem advisable.

THIS AUTHORIZATION SHALL REMAIN EFFECTIVE THROUGH THE 1ST DAY OF JULY, 2021.

Signed _____ Relationship _____

Witnessed by: _____ On: ____ / ____ / ____