

Form due by: May 17, 2015

Parental/Guardian Consent Form and Liability Waiver

Participant's Name: _____ DOB: ___/___/___

Parent/Guardian Name: _____

Home Address: _____

Email: _____

Home phone: _____ Emergency phone: _____

(please circle)

Gender: **M** **F** Grade: **9** **10** **11** **12** (2015-2016 school year) T-Shirt (Adult) **S** **M** **L** **XL**

I, _____, grant permission for my child,

Parent/Guardian name

_____ to participate in the Steubenville South Conference event

Child's name

which requires transportation to a location away from the parish site. This activity will take place under the guidance and direction of parish employees and volunteers from Holy Trinity Catholic Church.

The event information is as follows:

Date: June 26-28, 2015

**Type of Event: Steubenville South
Conference**

Place: Alexandria, Louisiana

Cost: \$230.00

Event phone contact: Renee Kuntz

Telephone number: (210) 497-4145 ext.333



As parent and/or legal guardian, I remain legally responsible for any personal actions taken by the above named minor (“participant”). I agree on behalf of myself, my child named herein, our heirs, successors and assigns to hold harmless and defend Holy Trinity Catholic Church, its officers, directors, and agents, and the Archdiocese of San Antonio from any and all liability for illness, injury or death arising from or in connection with my child’s attending the above named event and I agree to compensate the parish, its officers, directors and agents and the Archdiocese of San Antonio, or representative associated with the event for reasonable attorney’s fees and expenses arising in connection therewith.

Signature of Parent or Guardian

Date
(Over)

Medical Consent and Permission to Treat

To the best of my knowledge, my child, _____, is in good health,
And I assume all responsibility for the health of my child.

Emergency Medical Treatment: In the event of an emergency,

- I hereby grant permission to transport my child to a hospital for emergency medical treatment
___ **Yes** ___ **No**
- I wish to be advised prior to any further treatment by the hospital or doctor. **Yes** ___ **No** ___

Parent/Guardian's Name: _____

Home Address: _____

Home Phone: _____ Cell Phone: _____

If you are unable to reach me, please contact:

Name: _____

Relationship to me or my child: _____

Home Phone: _____ Cell Phone: _____

Family doctor: _____ Phone Number: _____

Please include a photocopy of your Insurance Card (front and back).

- Insurance Carrier: _____ Policy No: _____
- My child is taking medication and I will bring all medication & turn them into the Retreat Staff. It will be clearly labeled. All medication(s) and directions for taking this medication, including dosage, frequency and storage are as follows: _____

- I hereby grant permission for non-prescription medication (such as cough drops, cough syrup, Tylenol, etc.) to be given if necessary: ___ **Yes** ___ **No**
- I understand that aspirin will not be given to my child without my express permission. I hereby grant such permission: ___ **Yes** ___ **No**
- My child is allergic to the following (medications, foods, plants, insects, etc):

- My child's immunizations are current and up to date: ___ **Yes** ___ **No**
- My child's last tetnus/diphtheria immunization: _____
- My child has the following physical limitations: _____
- My child experiences homesickness, emotional reactions to new situations, sleep walking, fainting, bed wetting, etc. ___ **Yes** ___ **No** If Yes, please explain: _____
- My child has recently been exposed to a contagious disease or condition such as mumps, measles, chickenpox, etc. ___ **Yes** ___ **No** If yes, please state the date and disease or condition: _____

Signature of Parent or Guardian

Date