Diocese of Laredo  Office of Youth Ministry

PARENTAL/GUARDIAN CONSENT FORM AND LIABILITY WAIVER

Participant's Name: _____ Birth Date: _____

Parish: _____ Grade: _____Age: _____ Sex:_____

Address: _____ City: _____ Zip: _____

Parent/Guardian _____ Home Phone: (_____) _____

Who will pick up the child: _____

If this person is unable to pick up your child, you must submit in writing who will be doing so.

Consent & Liability Waiver

I, (Parent/Guardian) _____, grant permission for my child, (participant's name) _____, to participate in _____ to be held at _____.

I agree on behalf of myself, my son/daughter named herein, or our heirs, successors, and assigns, to hold harmless and defend the Diocese of Laredo, St. Patrick Church, Youth Ministry catechists/personnel, and other agents, etc. or any representatives associated with the scheduled activity or in connection with any illness or injury (including death) for reasonable attorney's fees and expenses which they may incur in any action brought against them as a result of such injury or damage.

_____ _____
Signature (Parent/Guardian) Date

_____ _____
Signature (Participant 18 years of age) Date

Photography Consent

As parent/guardian, I understand that promotional pictures (individual and group) will be taken during any Youth activity or event. I give permission for my son/daughter's picture to be used for promotional materials (newsletter, newspaper, media, etc.) in highlighting the activity/event.

_____ _____
Signature (Parent/Guardian) Date

MEDICAL CONSENT

I hereby warrant to the best of my knowledge, my son/daughter, to be in good health, and I assume all responsibility for the health of my child. (Of the following statements pertaining to medical matters, sign only those in accordance with your wishes.)

In the event of any emergency, I hereby give permission to transport my son/daughter to a hospital for emergency medical or surgical treatment. I wish to be advised prior to any further treatment by the hospital or doctor. In the event of an emergency and you are unable to reach me, contact:

*Name & Relationship*_____ *Phone (___)* _____

Family Doctor: _____ *Phone (___)* _____

Medications

My son/daughter will bring needed medication(s), well-labeled, and concise directions for such medications, including dosage and frequency. My son/daughter is taking the following medication(s) at the present time.

Medication: _____ *Dosage:* _____

Medication: _____ *Dosage:* _____

(If more medications need to be listed, please provide on another page.)

Please initial one:

_____*I hereby* ***DENY PERMISSION*** *for medication of any type, whether prescription or non-prescription be administered to my child unless the situation is life threatening and emergency treatment is required.*

_____ *I hereby* ***GRANT PERMISSION*** *for non-prescription medication (such as Tylenol, throat lozenges, cough syrup) to be given to my child, if deemed advisable. I understand that* ***aspirin*** *will not be given to my child.*

Medical Conditions Information

(Diocesan personnel will take reasonable care to see that the following information will be held in confidence.)

Has had an episode or has been diagnosed: ☐ *Seizures* ☐ *Asthma* ☐ *Diabetic*

Allergic reactions to the following (foods, dyes, latex, etc.) _____

Has had a medical surgery within the last six months? ☐ *Yes* ☐ *No Still under doctor's care:* ☐ *Yes* ☐ *No*

Has a medically prescribed diet: _____

Has physical limitations: _____

Immunizations are current and up to date: ☐ *Yes* ☐ *No Date of last tetanus/diphtheria immunization* _____

You should also be aware of these special medical conditions of my child: _____

Insurance Information

Please attach a copy of the Insurance Card, front and back, with this form.)

Insurance Carrier: _____ *Policy #* _____

Name of Insured: _____ *Insurance ID #:* _____

Father's Name: _____ *Birth Date:* _____

Place of Employment: _____ *Phone #:* _____

Mother's Name: _____ *Birth Date:* _____

Place of Employment: _____ *Phone #:* _____

☐ *No, I do not carry medical insurance at this time.*

In the event it comes to the attention of the chaperones associated with the activity that my child becomes ill with repeated symptoms such as headache, vomiting, sore throat, fever, diarrhea, I want to be called immediately. If this will be a long distance call, I want to be called collect (with phone charges reversed to myself). I fully understand the foregoing statements and sign this Parent/Guardian Medical Consent Waiver knowingly, freely, and willingly.

_____ _____

Signature (Parent/Guardian) ***Date***