Diocese of Laredo - Office of Youth Ministry
St. Patrick Life Teen, St. Patrick Parish, Laredo
Fire and Ice Retreat
stpatricklifeteenlaredo@gmail.com

Parental/Guardian Consent, Liability Waiver and Medical Consent

Participant's Name ______________________________

Birth date____________ Sex__________ Age______ Grade ________

Participant's Home Address ______________ Cell__________________

City______________________________ State ______________

Parish______________ City ______________________________

Parent/Guardian ______________________________

Home Phone__________ Business Phone____________ Cell Phone __________

Consent & Liability Waiver

I,____ grant permission for my child,
Parent or Guardian

________________To be at St. Patrick Church. Person in charge is Gwen Garza.

I agree on behalf of myself, my child named herein, or our heirs, successors, and assigns, to hold harmless and defend the **DIOCESE OF LAREDO,** the sponsoring Parish (its pastor, youth minister, and other agents, etc.) or any representative associated with the scheduled activity or in connection with any illness or injury (including death) or cost of medical treatment and I agree to compensate the **DIOCESE OF LAREDO**, the sponsoring Parish (its pastor, youth minister, and other agents, etc.) or any representative associated with the event 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*

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***