Religious Education for Children

Diocese of Laredo

1201 Corpus Christi St., Laredo, TX 78041
(956) 727-2140 ext. 7833 or 7832

PARENTAL/GUARDIAN CONSENT AND LIABILITY WAIVER

Participant's Name: ______________________________ *Birth Date :* ______________ *Shirt Size* ____

Parish: ______________________________________ *Grade:* _____ *Age:* ________ *Sex.* ______

Address: ____________________________________ *City:* _________________ *Zip:* __________

Parent/ Guardian: _________________________________ *Home Phone:* (____) ____________

Email ____

Consent & Liability Waiver

I, (Parent/Guardian) ____, grant permission for my child, (Participant's Name) ____ to participate in the ……………………………………… be held at ……………………, located at ………………, Laredo, TX. 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 representatives 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, Disability Ministry, and other agents, etc.) or any representatives associated with the event for reasonable attorneys' 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 this event. I give permission for pictures to be used for promotional materials (newsletter, newspaper, media, etc.) in highlighting the event.

____ _____________________________

Signature *Date*

MEDICAL CONSENT

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

Emergency Medical Treatment
In the event of any emergency, I hereby give permission to transport my child 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 child will bring all such medications, well labeled, that are necessary. Names of medications and concise directions for seeing that the child takes such medications, including dosage and frequencies are as follows:

My child is taking the following medications at the present time:
*Medication(s):*____________________ *Dosage:*____________
____________________ *Dosage:*____________
Administer: ________________________________
(If more medications are needed please provide on another page.)
______: *I hereby* ***Do Not Grant Permission*** *for medication of any type, whether prescription or nonprescription to be administered to my child unless the situation is life threatening and emergency treatment is required. (Please initial)*

______: *I hereby* ***Grant Permission*** *for nonprescription 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 son/daughter. (Please initial)*

Medical Conditions Information

(Diocesan personnel will take reasonable care to see that the following information will be held in confidence.) My son/daughter
Has had an episode of the following 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? ____________________
The following physical limitations? ____________________
Immunizations 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: ______________________________
Name of Insured: ______________________________
Insurance ID Number: ________________ *Insurance Policy Number:*____________
Father's Name: ________________ *Birth Date:* ____________
Place of Employment: ________________ *Phone Number:* (____) ____________
Mother's Name: ________________ *Birth Date:* ____________
*Place of Employment:*________________ *Phone Number:* (____) ______
☐ *N, 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 reverses to myself). I fully understand the foregoing statements and sign this Parent/Guardian Medical Consent Waiver knowingly, freely, and willingly.

______________________________ ____________
Signature (parent/Guardian) must sign for anyone under 18 years of age. ***Date***

______________________________ ____________
Signature (Participant) ***Date***