Jesus Alive & Living Butler District Youth Group

PARISH EVENT/TRIP PARENTAL PERMISSION & MEDICAL RELEASE FORM

Student's Name Age Sex

☐ Parishioner of______________________________ ☐ Non Parishioner, Friend of ____________________________________

Address City State Zip Home Phone

School Grade Birth Date E-Mail

Date(s) of Event Time(s) of Event Description/name of Event/Trip Including Location(s) to be visited

Chaperones Needed: Can a parent chaperone or assist? ☐ **No** ☐ **Yes – Parent Name**______________________

Is the parent Safe Environments Compliant? ☐ **No** ☐ **Yes** ☐ **Not Sure**

Medical Authorization

In the event of any injury or illness to my/our child during his/her participation in this one-day (or less) program, I/we hereby give my/our permission for the necessary medical treatment to be given to my/our child. I/we agree that in case of injury to my/our child, we will apply my/our hospitalization and/or or accident insurance toward payment of the expenses incurred and will not look to the parishes of JAL or any other program sponsor or volunteer for the payment of any medical costs or injury related costs.

Parent/Guardian Signature(s) Name(s) (Please Print) Date

Phone number(s) for emergency

Insurance Company Policy and/or ID number(s)

Name and phone number of person to call if parent is not available.

ATTENTION: PLEASE COMPLETE REVERSE SIDE ALSO!

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PARISH EVENT/TRIP PARENTAL PERMISSION & MEDICAL RELEASE FORM

Student's Name____ Home Phone________________________

CONSENT TO TREAT

I/We, the undersigned parent(s)/guardian of ____________________________, a minor, do hereby authorize treatment of my/our child by a licensed medical physician in case of any accident or illness that may so arise, or any hospitalization necessary. This medical consent will remain effective until **(date)**______________________**.**

____ ______________________________________

Signature Father/Legal Guardian Date Phone(s) where you can be reached

____ ______________________________________

Signature Mother/Legal Guardian Date Phone(s) where you can be reached

MEDICAL MATTERS: I hereby warrant that to the best of my knowledge, my child is 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.)***

1) Medications: My child is **taking medication at present.** My child will bring all such medications necessary, and such medications will be well labeled. My child will be responsible to administer his/her own medication.

Name of medication, time, and dosage ____

Signature____Date______________________________

2) I hereby **grant permission for nonprescription medication** (such as Tylenol, throat lozenges, cough syrup) to be given to my child if deemed advisable.

Signature____Date______________________________

3) **No medicating of any type**, whether prescription or non-prescription may be administered to my child unless the situation is life-threatening and emergency treatment is required.

Signature____Date______________________________

Known allergies:____

Known physical limitations:____

Medically prescribed dietary needs:____

Is child a vegetarian? ☐ No ☐ Yes

Is child subject to chronic homesickness, emotional reactions to new situations, sleepwalking, fainting? ☐ No ☐ Yes

Does child have any other special needs? ☐ No ☐ Yes – Please briefly describe___________________________

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ATTENTION: PLEASE COMPLETE REVERSE SIDE ALSO!