PARENT REQUEST TO PARTICIPATE & MEDICAL RELEASE FORM

Dear Parent or Legal Guardian:

Your son/daughter is eligible to participate in a church/school-sponsored event. This activity will take place under the guidance of ______Ray Lacy______________________________. A brief description of the activity follows:

Name of Event: ___National Catholic Youth Conference (NCYC 2019)__________

Destination:______Indianapolis, IN____

Designated Supervisor of Activity:___Ray Lacy______________________________

Date and Time of Departure:__Nov 20 2019 @ 7:00PM – Biloxi Pastoral Center__

Method of Transportation:_Hotard Bus__________________________________

Approximate Cost:__$550.00_____________

If you would like your child to participate in this event, please complete, sign, and return the following statements of consent and release of liability. As parent or legal guardian, you remain fully responsible for any legal responsibility that may result from any personal actions taken by the named student.

I hereby consent to participation by my child, ____
In the event described above. I understand that this event will take place away from the church/school grounds and that my child will be under the supervision of the designate chaperons on the stated dates. I further consent to the conditions stated above on participation in this event, including the method of transportation.

____
Print Parent's Name   Cell Phone   Email

____
Parent's Signature   Date

SWORN TO and subscribed before me on this ________ day of ___________ 20________

____
NOTARY PUBLIC
(Seal)

My commission expires: ____________________________

Only overnight trips require notarization.

YOUTH

Youth Trips & Other Functions

MEDICAL RELEASE AND INFORMATION FORM

(Medical Information for Overnight Trips/Retreats Only)

Name of participant____ DOB _______________

Medication presently on (Name and dosage for each)

____

____

____

Allergies (Foods, Medication, etc.):

____

____

____

Any other Medical conditions (asthma, diabetes, seizures etc)

____

____

____

Date of last tetanus shot ______________________________________

____

Parent contact: Work Phone Cell Phone Email:

____

Contact Person (alternate) Home Phone Work Phone Cell Phone

I hereby give my permission for my child to be administered medical help in case of an emergency. If you have medical insurance please indicate the following:

Insurance Company: _____________________________ Phone: ______________________

Policy Name: _____________________________ Policy Number: ______________________

Family Doctor: ___________________________________ Doctor's Phone Number: ________________

Parents(s) Guardian(s) signature ____________________________________ Date: ___ / ___ / ______

Sworn To and subscribed before me on this _______ day of _________ 20____________

____

Notary Public (seal)

My commission expires: ________________