YOUTH ACTIVITY PERMISSION FORM

Our Lady of Prompt Succor / Diocese of Lake Charles, LA

Participants Full Name: _____
First Middle Last

Date of Birth: _____

Home Address: _____ **City:** _____ **State:** ___ **Zip** ____

Home Phone: _____ **Parents cell / work** _____
Student's cell _____

I (we), the parents of the above named minor grant permission for my child to participate in the youth activities under the direction of the Diocese of Lake Charles, Our Lady of Prompt Succor.

I (we) give our permission and authorization to furnish all necessary supervision, transportation, food, and lodging for the participant.

Furthermore, I (we) agree to indemnify and hold harmless the Diocese of Lake Charles, Our Lady of Prompt Succor, and/or appointed volunteers from all actions other than acts of negligence or intentional injury.

I (we) hereby warrant that to the best of my/our knowledge, our child is in good health and I/we assume all responsibility for the health of my/our child. In the event of an emergency, I/we give permission to transport my/our child to a hospital for emergency or surgical treatment.

Furthermore it is agreed that if it becomes necessary for my/our child to return home before the completion of an activity for health or disciplinary action I (we) assume responsibility and transportation cost.

Father / Mother / Legal Guardian ***Signature:*** **(circle one)**

_____ **Date:** _____

Participant's ***Signature*** _____ **Date:** _____

OVER →

Student's NAME _____

Name of Physician _____ **phone #** _____

Allergies: _____

Current Medications: _____

Medical History: _____

IN CASE OF EMERGENECY, PLEASE CONTACT:

Name: _____ **Name:** _____

Address: _____ **Address:** _____

Day phone: _____ **Day phone:** _____

Evening Phone: _____ **Evening phone:** _____

Cell : _____ **Cell:** _____

EMERGENCY MEDICAL TREATMENT

In the event of an emergency, I hereby authorize Mrs. Terry Sittig and/or ANY RESPONSIBLE ADULT to take my child to a physician or hospital for emergency treatment. I also authorize any licensed physician or hospital to treat my child. Notwithstanding and question of liability involved in this emergency, I agree as Parent or Guardian of this child to be fully responsible for the cost and payment of the treatment.

Signature: _____ **Date:** _____

HOSPITALIZATION INFORMATION

Company: _____

Policy # _____

Group # _____

Phone # _____

Name of Insured: _____