



Diocese of Corpus Christi  
\_\_\_\_\_Vocation Office - EXPLORE 2019\_\_\_\_\_

**PARENTAL/GUARDIAN CONSENT, LIABILITY WAIVER AND  
MEDICAL CONSENT**

Participant's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Home Address \_\_\_\_\_

City \_\_\_\_\_ Zip Code \_\_\_\_\_

Parent(s)/Guardian(s) \_\_\_\_\_

Cell Phone (\_\_\_\_\_) \_\_\_\_\_ Home Phone (\_\_\_\_\_) \_\_\_\_\_

Email Address: \_\_\_\_\_

Parish or Catholic School \_\_\_\_\_ Grade \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

**PARTICIPATION CONSENT, LIABILITY WAIVER &  
PHOTOGRAPHY/VIDEOGRAPHY CONSENT**

**Important!** To be filled out by the Parent/Guardian for youth under 18 years of age.  
(If participant is 18 years of age or older, consent must be signed by the individual)

I (name of parent/guardian) \_\_\_\_\_, grant  
permission for my child, (participant's name) \_\_\_\_\_,  
to participate in EXPLORE 2019 to be held July 22 - 26, 2019  
Camp Aranzazu 5420 Loop 1781 Rockport, TX. 78382-7622

I agree on behalf of myself, my child's other parent if known or living (name of parent) \_\_\_\_\_,  
my child named herein, or our heirs, successors, and assigns, to release and hold harmless and defend the  
Diocese of Corpus Christi, the sponsoring parish (its pastor, youth minister, principal, other agents, etc.) or any  
representatives associated with the scheduled activity from all damages, claims, suits, expenses and payments for  
injury to my child and/or property, including all damages, claims, suits, expenses and payments resulting from the  
negligence of the Diocese of Corpus Christi, and parish, and/or their officers, directors, and employees.

**As parent/guardian, I understand that promotional pictures (individual and group) will be taken during this  
event. I give permission for my son's/daughter's picture to be used for promotional materials (newsletter, web  
page, calendars, power point, video, etc.) in highlighting the event.**

\_\_\_\_\_  
**Signature (Parent/Guardian)**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Signature (Participant 18 years of age or older must sign own consent)**

\_\_\_\_\_  
**Date**



## MEDICAL CONSENT

### Medical Matters

I hereby warrant 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:

#### Emergency Medical Treatment

In the event of an 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 frequency are as follows:

Medication(s): \_\_\_\_\_ Dosage: \_\_\_\_\_

Administer: \_\_\_\_\_

\_\_\_\_\_ I hereby **Do Not Grant Permission** for medication of any type, whether prescription or nonprescription may be administered by 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 Policy Number: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Day Phone: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Day 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 Parental/Guardian Medical Consent Waiver knowingly, freely, and willingly.

\_\_\_\_\_  
**Signature (Parent/Guardian)**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Signature (Participant 18 years of age or older must sign own consent)**

\_\_\_\_\_  
**Date**