PARENTAL/GUARDIAN CONSENT, LIABILITY WAIVER AND MEDICAL CONSENT

Participant's Name ______________________ Date of Birth ____________

Home Address ____

City ______________________ Zip Code ______

Parent/ Guardian ______________________ Home Phone (   ) ____________

Alternate Phone Number (   ) ______________ Cell ☐ Pager ☐

Parish ______________________ Grade ____ Age ____ Sex ____

CONSENT & LIABILITY WAIVER

Important: To be filled out by the Parent/Guardian for youth under 18 years of age
If Participant is 18 years 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

(event) ______________________________ to be held

(date) ________ (time) ________ and (location) ______________________

I agree on behalf of myself, my child's other parent if known or living (name of parent) ______________
My child named herein, our heirs, successors, and assigns, to hold harmless and defend the Archdiocese of Galveston-Houston, the sponsoring parish (it's pastor, youth minister, other agents, etc.) or any representative associated with the scheduled activity unless the parties involved were careless or negligent.

______________________________ ____________
Signature (Parent/Guardian) **Date**

______________________________ ____________
Signature (Participant 18 years of age or older must sign own consent) **Date**

PHOTOGRAPHY CONSENT

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, etc.) in highlighting the event.

______________________________ ____________
Signature (Parent/Guardian) **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 treatment by the hospital or doctor.

In the event of an emergency and you are unable to reach me:

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 as follows:

My child is taking the following medication at the present time.

Medications) ______________________ dosage ______________________

Administer: ______________________

I hereby **Do Not Grant Permission** for medication of any type, whether prescription of nonprescription my be administered to my child unless the situation is life threatening and emergency treatment is required.

I hereby **Grant Permission** for the 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

(Archdiocesan personnel will take reasonable care to see that the following information will be held in confidence)

My son/daughter has:

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

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 Issued ______________________

Insurance ID Number ______________________ Insurance Policy Number ______________________

Fathers name ______________________ Birth date ______________________

Place of Employment ______________________

Mothers Name: ______________________ Birth Date ______________________

Place of Employment ______________________

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 it 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**