St. Joseph, Mantua Parish School of Religion

YOUTH Registration, Medical Release and Permission Combined Form

(Please print or type all information, except signatures, and complete both sides of this form.)

I. First Name: _____ Middle Initial: _____ Last Name: _____

Address: _____

City, State, Zip: _____ Home Phone: _____

Email address: _____

Parish/School (group you are registered with): _____

Mother/Guardian: _____ Father/Guardian: _____

Additional Emergency Phone numbers (please identify as work, cell, pager, etc.): _____

Date of birth: _____ Grade: PreK K 1 2 3 4 5 6 7 8

Circle ALL that apply: Male Female Mobility Impaired Wheelchair Access

Hearing Impaired/Interpretation Needed Visually Impaired (more than wearing glasses)

Please note: All areas utilized are not ADA accessible. Contact (YOUR PARISH) if special arrangements need to be made.

II. Youth Agreement (Grades 6-8)

I understand that my participation in this program requires compliance with specific regulations for this program. I agree to abide by all rules and regulations set forth. Any infraction of the rules or regulations, including disrespect towards my peers and my teacher, and the possession of any illegal material, may cause my dismissal from the program. If I should be dismissed, I understand that my parents will be contacted to arrange for my immediate transportation home.

Youth Signature: _____ **Date:** _____

III. Parental Agreement

I, the parent/guardian of _____ who is less than nineteen years of age, grant permission for my daughter/son to participate in St. Joseph Parish's School of Religion and all related programs. By allowing my child to participate in the said program, I hereby assume all risk of accident or harm arising or growing out of, directly or indirectly, any incident of any kind occurring during the course of such program to my child and do hereby release and discharge the Bishop of the Diocese of Youngstown, and St. Joseph Parish, Mantua, and the agents, associates, and employees of the Bishop and parish/school who have organized or participated in the supervision of such program from all claims, demands, suits, causes or actions, rights, costs, expenses, and any compensations whatsoever which may occur to my family and its members during or resulting from participating in the program mentioned.

Signature: _____ **Date:** _____

I am aware of the particulars of the said program including the times, costs, adults supervising and/or transporting my child for the program and have clarified any concerns I may have with the coordinating adult in charge. I agree that my son/daughter shall abide by the rules and all regulations of the program including in regards to the PSR Code of Conduct. I agree that if my son/daughter fails to abide by the regulations set forth, he/she may be dismissed from the program and I will need to arrange for his/her immediate transportation home at my expense.

Signature: _____ **Date:** _____

(Continued on back)

IV. Medical Information

(Please read all the options below, then check and sign only those that are in accordance with your wishes.)

☐ In the event of an emergency, I hereby grant permission to transport my son/daughter and obtain emergency medical or surgical treatment from a licensed physician, hospital, or medical clinic. I hereby authorize medical personnel to release necessary information about his/her care to the parish or school group leaders(s) named here _____. I wish to be advised prior to further treatment by the hospital or doctor. In the event I cannot be reached, please contact _____ at _____. Relationship to youth _____.
Family physician _____. Phone _____.

(Please check one of the following)

☐ My son/daughter is covered by hospitalization and medical insurance under policy # _____ _____ issued by _____.

☐ My son/daughter does not have medical coverage and I assume responsibility for the cost of hospitalization and medical care for my son/daughter.

Signature: _____ **Date:** _____

☐ I hereby warrant that to the best of my knowledge, my son/daughter is in good health. **I do not want any medical treatment to be given to my son/daughter under any circumstances.** I hereby assume all responsibility for the health and well being of my son/daughter and release from responsibility the Bishop of the Diocese of Youngstown, and _____ parish/school, and the agents, associates, and employees of the Bishop and parish who have organized or participated in the supervision of such program.

Signature: _____ **Date:** _____

☐ My son/daughter is taking medications at present. He/she will bring all necessary medications and such medications will be well labeled. The names of, and concise directions for taking such medications, including dosage and frequency of dosage are as follows: _____

_____

Signature: _____ **Date:** _____

☐ No medication of any type whether prescription or nonprescription may be administered to my child unless the situation is life threatening and emergency treatment is required.

Signature: _____ **Date:** _____

☐ I hereby grant permission for nonprescription medication (such as acetaminophen, decongestant, cough syrup) to be given to my son/daughter, if requested by my son/daughter and deemed advisable by an adult chaperone.

Signature: _____ **Date:** _____

☐ I wish to inform you of the following additional medical information and the recommended course of action (allergies, dietary restrictions, special conditions, etc.)_____

_____

Signature: _____ **Date:** _____

☐ I would like to have a member of the St. Joseph PSR staff speak with me further regarding a medical concern or situation. Please contact me at _____.