

A DAY OF REFLECTION
PARENTAL/GUARDIAN CONSENT FORM AND LIABILITY WAIVER
UNDER 17 YRS OLD ONLY

Participant's Name: _____ Birth Date: _____ Sex: _____

Parent/Guardian's Name: _____

Home Address: _____ City/State _____ Zip _____ Home

Phone: _____ Business Phone: _____ Cell Phone: _____

I, _____, grant permission for my child, _____ to participate in this youth ministry event. This activity will take place under the guidance and direction of employees and/or volunteers from Catholic Diocese Vocation Office. A brief description of the activity follows:

Type of Event: A Day of Reflection

Date of Event: July 24, 2010- Saturday

Destination of Event: St. Joseph Multi-Purpose Center

Individual in Charge: Vocation Office

Mode of Transportation to and from event: Responsibility of parent or guardian

As parent and/or guardian, I remain legally responsible for any personal actions taken by the above named minor ("participant"). I agree on behalf of myself, my child named herein, or our heirs, successors, and assigns, to hold harmless and defend _____, its officers, directors and agents, and the Roman Catholic Diocese of El Paso, chaperons, or representatives associated with the event, arising from or in connection there with, and agree to compensate the parish, its officers, directors and agents, and the _____, chaperons, or representative associated with the event for reasonable attorney's fees and expenses arising in connection therewith.

Signature: _____ Date: _____

MEDICAL MATTERS: I hereby warrant that 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 that are applicable).

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, if you are unable to reach me at the above numbers, contact:

Name and Relationship: _____

Phone: _____ Family Doctor: _____ Phone: _____

Family Health Plan Carrier: _____ Policy #: _____

Signature: _____ Date: _____

OTHER MEDICAL TREATMENT: In the event it comes to the attention of the parish, its officers, directors and agents, and the Roman Catholic Diocese of El Paso, chaperons, or representatives associated with the activity that my child becomes ill with symptoms such as headache, vomiting, sore throat, fever, diarrhea, I want to be called collect (with phone charges reversed to myself).

Signature: _____ Date: _____

Medications: My child is taking medication at present. My child will bring all such medications necessary, and such medications will be well-labeled. Names of medications and concise directions for seeing that the child takes such medications, including dosage and frequency of dosage, are as follows:

Signature: _____ Date: _____

I hereby grant permission for non-prescription medication (such as aspirin, throat lozenges, cough syrup) to be given to my child, if deemed appropriate.

Signature: _____ Date: _____

SPECIFIC MEDICAL INFORMATION:

Allergic reactions (medications, foods, plants, insects, etc.): _____