Catholic Diocese of El Paso and/or the Parish of

_____

Annual Youth Ministry Parent/Guardian/Conservator Permission, Liability Waiver and Medical Information

Participant's Name: _____

Birth Date: _____ **Sex: Male ☐ Female ☐**

Parent ☐ Guardian ☐ Conservator ☐ Name: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Cell Phone: _____ **Home Phone:** _____

Emergency Contact Name: _____

Relationship to my son/daughter: _____

Cell Phone:(_____) _____ **Home Phone: (**_____) _____ Texting: Yes ☐ No ☐

Release/Indemnification Information:

I, _____ *grant my permission for* _____
Parent/Guardian/Conservator's Name *Participant's Name*

to participate with the Youth Ministry and activities of the Diocese of El Paso and/or the parish of _____ *beginning the* _____ *and continuing through the* _____. *These various programs and activities will take place under the guidance and direction of Parish Youth Leaders, catechists and/or volunteers from the parish of* _____. *This permission and liability waiver will be kept on file and will accompany the child on any and all programs and activities of the Diocese of El Paso and/or parish. A separate* ***FORM B*** *Consent to Participate and Consent Emergency Medical Treatment must be filled out and turned in to accompany this form per each program and/or activity.*

I understand that as parent/guardian/conservator, I remain legally responsible for any personal actions taken by the participant named above.

I agree on behalf of myself, my son/daughter/participant named herein, our/his/her heirs, successors, and assigns to hold harmless, the Diocese of El Paso, the Bishop and his successors, employees, agents, volunteers, the Parish its employees and volunteers from any and all claims (unless due in part by gross negligence of the Diocese and/or Parish) for illness, injury, death and the cost of medical treatment therewith, arising from or in any way connected with my son/daughter/participant's attending the various programs and activities during the dates named above.

In the event any legal action is taken by either party against the other party to enforce any of the terms and conditions of this agreement, it is agreed that the unsuccessful party to such action shall pay to the prevailing party therein all reasonable court costs, reasonable attorneys' fees and expenses incurred by the prevailing party.

→ **Parent/Guardian/Conservator Signature** _____ **Date** _____

Promotional Release

I also consent to the use of any videotapes, photographs, slides, audiotapes, or any other visual or audio reproduction (in perpetuity unless otherwise revoked by me in writing and delivered by certified mail, return receipt requested, to: Youth Office, 499 St. Matthews St., El Paso, TX 79907 ATTN: Director, Youth Ministry) in which my son/daughter may appear by the Diocese of El Paso. I understand that these materials, including websites and social media sites, are being used for promotion of the Youth Ministry of the Diocese of El Paso, which may include recruitment and fundraising efforts.

→ **Parent/guardian/Conservator Signature** _____ **Date** _____

Social Media Release

The Diocese of El Paso utilizes today's technology in a positive way to reach out to the youth of the diocese, including Facebook, email, and other social media; we may remove any content deemed inappropriate; all communications with any youth through social media programs by anyone representing the diocese may be made available to any parent upon request; if you do not allow your son/daughter to text, Facebook, or use other social media, there will be no expectation that they do so in order to participate in certain religious formation events; however, the diocese cannot guarantee that photos, videos, or other communication of you son/daughter from diocesan and /or parish events will not be uploaded to a social media site.

→ **Parent/Guardian/Conservator Signature** _____ **Date** _____

Is the participant insured? Yes ☐ No ☐
If yes, please fill out the information below *FROM THE PARTICIPANTS* Insurance Card:

Name of Policy Holder (whose name is the policy in?) _____

Insurance Carrier/ Name of Insurance Company: _____

Policy Number: _____ Insurance ID Number: _____

Claim Address: _____

Customer Service Phone Number: _____

Prescription Medications: Check Box 1, 2, *or* 3 which is true for your child - DO NOT CHECK ALL BOXES

❑ 1. My son/daughter takes no medication and will bring no medication with him/her.

❑ 2. My son/daughter takes medication/s and will self-medicate. My son/daughter will bring all such medications necessary, and such medications will be clearly labeled. I understand that the child will be required to turn all medication(s) over to a supervising adult designated to keep medication(s). I further understand that it will be this child's responsibility to present himself/herself at a location designated for returning medication(s) to my son/daughter at the frequencies/times listed below. I understand that the adult to whom he/she surrenders the medication has no medical training and this adult will not measure dosages. My son/daughter will return the medication(s) to the adult after he/she self-medicates. At the conclusion of the event it will be my son/daughters responsibility to pick up remaining medication(s), if any, at the self-medication designated location. Names of medications and exact dosage and frequencies / times are as listed below: (you may attach a sheet to this form if you need more space just make sure to sign and date it as well).

_____

_____

❑ 3. My son/daughter takes medication but is unable to self-medicate. I, parent/guardian/conservator, will provide and dispense any and all needed medications.

Non-Prescription Medications: Check Box A or B. DO NOT CHECK BOTH BOXES

❑ **A. No medication of any type** whether prescription or non-prescription may be administered to this child unless the situation is life-threatening and emergency treatment is required.

❑ **B**. **I grant permission** for the following non-prescription medication to be given to this child (excluding medication listed below that causes allergic reaction) in the recommended dosage on the medication bottle.

Non-aspirin pain reliever:	Yes ☐ No ☐
Throat Lozenge:	Yes ☐ No ☐
Decongestant:	Yes ☐ No ☐
Antacid:	Yes ☐ No ☐
Antihistamine:	Yes ☐ No ☐

Specific Medical Information

1. Allergic reactions (medications, foods, plants, insects, etc.)

2. Other medications child currently takes

3. Any physical limitations

4. Has child recently been exposed to contagious disease or condition such as mumps, measles, chicken pox, etc.? If so, date and disease or condition.

5. You should also be aware of these special medical conditions of this child. *Please attach a clear description to this form*

To the best of my ability, everything I have stated here is true and accurately reflects my wishes.

→ **Signature of Parent/Guardian/Conservator:** _____ **Date:** _____