

**PARENTAL CONSENT FORM AND LIABILITY WAIVER**  
**Please Print except where signature is required**

Participant's Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: (\_\_\_\_) \_\_\_\_\_ Age: \_\_\_\_\_ Gender: M \_\_\_ F \_\_\_ Shirt Size: \_\_\_\_\_  
Cell Phone (\_\_\_\_) \_\_\_\_\_ Free Texting? \_\_\_ yes \_\_\_ no  
E-mail: \_\_\_\_\_ Parish: \_\_\_\_\_

**MEDICAL MATTERS**

I hereby warrant that to the best of my knowledge, my child is in good health, 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 the 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 number or at my business \_\_\_\_\_, business phone (\_\_\_\_) \_\_\_\_\_.

Contact Name: \_\_\_\_\_  
Relationship: \_\_\_\_\_  
Phone Number: (\_\_\_\_) \_\_\_\_\_ work: (\_\_\_\_) \_\_\_\_\_  
Family Doctor: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_  
Family Health Plan Carrier: \_\_\_\_\_  
Policy Number: \_\_\_\_\_

\_\_\_\_\_  
Signature of Parent/Guardian Date

**OTHER MEDICAL TREATMENT**

In the event, it is brought to the attention of the Diocesan agents, chaperones or representatives associated with the event 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

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 the medications, including dosage and frequency of dosage is as follows:

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Signature

Date

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

Signature

Date

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

Signature

Date

#### SPECIFIC MEDICAL INFORMATION

The Diocese will take reasonable care to see that the following information will be held in confidence.

Immunizations: Date of last Tetanus/diphtheria immunization: \_\_\_\_\_

Does the child have a medically prescribed diet? \_\_\_\_\_

Any physical limitations? \_\_\_\_\_

Is the child subject to chronic homesickness, emotional reactions to new situations, i.e., sleepwalking, bed wetting, fainting, migraine headaches? \_\_\_\_\_

Has the child recently been exposed to contagious disease or condition, such as mumps, measles, chickenpox, etc.? If so, date and disease or condition: \_\_\_\_\_

You should be aware of these special medical conditions of my child:

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SPECIAL DIETARY NEEDS: \_\_\_\_\_

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This form is good for 2 years from this date: \_\_\_\_\_

Parent or guardian must notify youth minister of any changes to the information provided when necessary.