

PARENTAL/GUARDIAN CONSENT FORM & LIABILITY WAIVER

Participant's Name _____ Date of Birth _____

Home Address _____ City/Zip Code _____

Parent(s)/Guardian(s) _____ Home Number _____

Parent Contact # _____ Text? Y / N Youth Contact # _____ Text? Y / N

Participant's School Name _____ Grade _____ Age _____ Sex _____

Parent's Email Address _____

T-Shirt Size (Adult Sizes Circle One): S M L XL XXL XXXL Family Envelope #: _____

Name of one person you would like to room with (if applicable): _____

CONSENT & LIABILITY WAIVER

**Important! To be filled out by the Parent/Guardian for youth under 18 years of age.
(If participant is 18 years of age 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) Theology of the Body Workshop to be held February 25, 2018
(1:00-5:00PM); March 4, 2018 (1:00-5:00PM) at Epiphany of the Lord Catholic Community, PAC.

I agree on behalf of myself, my child's other parent if known or living (name of parent), _____, my child named herein, or our heirs, successors, and assigns and defend the Archdiocese of Galveston-Houston, the sponsoring parish (its pastor, youth ministry leader, principal, other agents, etc.) or any representatives associated with the scheduled activity unless the parties involved were careless and negligent.

In signing this form I certify that all information contained herein is true and accurate to the best of my knowledge.

Signature (Parent/Guardian) _____
Date

YOUTH PARTICIPANT: In signing the line below I agree to abide by any/all policies and rules established for this event/activity (see Code of Conduct). Should I not be able to maintain the guidelines and expectations of the adults and my peers, I understand that there will be consequences for my actions, including being removed from the activity and being sent home at my parent's expense.

Signature (Youth Participant) _____
Date

VIDEO/PHOTOGRAPHY CONSENT

As parent/guardian, I understand that promotional pictures and videos (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, video etc.) in highlighting the event.

Signature (Parent/Guardian) _____
Date

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 any further treatment by the hospital or doctor and I understand that all financial obligations are my responsibility.

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

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 frequencies are as follows:

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

Medication(s): _____ Dosage: _____

Administer: _____

_____ I hereby **Do Not Grant Permission** for medication of any type, whether prescription or nonprescription may be administered by my child unless the situation is life threatening and emergency treatment is required. (Please initial)

_____ I hereby **Grant Permission** for non-prescription 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 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? Yes No
- 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 (e.g. depression, anxiety, etc.):

Insurance Information: **No, I do not carry medical insurance at this time.**

Insurance Carrier: _____ Name of Insured: _____

Insurance Policy Number: _____

Father's Name: _____ Day Phone: _____

Mother's Name: _____ Day Phone: _____

In the event that my child becomes ill with repeated symptoms such as headache, vomiting, sore throat, fever, diarrhea, I want to be called immediately. I fully understand the foregoing statements and sign this Parental/Guardian Medical Consent Waiver knowingly, freely, and willingly.

Signature (Parent/Guardian) Parent/Guardian must sign for anyone under 18 years of age.

Date

Signature (Participant 18 years of age or older must sign own consent)

Date