



**FORM OF CONSENT OF PARENT OR GUARDIAN
DISCLAIMER OF LIABILITY FOR MEDICAL CARE**

PARTICIPANT INFORMATION

Name: _____ Date of Birth: _____ M _____ F _____

email: _____

Home Address: _____ City _____ State _____ Zip _____

Home phone number: _____ Cell phone number: _____

PARENT/GUARDIAN INFORMATION

Father's Name : _____ Mother's Name _____

Address: _____ Home phone: _____

Parent email: _____

Parent Work phone: _____ Parent Cell phone : _____

I, _____ (parent/guardian) grant permission to _____ (name of youth) to participate in this parish youth ministry event that requires transportation to a location away from the parish site. This activity will take place under the guidance and direction of parish employees from St. Peter the Apostle Catholic Parish. A description of the activity follows:

Name of event or activity: _____

Destination of event or activity: _____

Name of individual in charge: Nick Petro, Coordinator of Youth Ministry

Estimated time of departure and return: Departure: _____ Return: _____

Mode of transportation to and from the event: _____

As parent and/or legal guardian, I remain legally responsible for any personal actions taken by _____ (name of youth) during this event. I, _____ (parent/guardian) agree on behalf of myself, my child's other parent if known or living, or our heirs, successors and assignees, to hold harmless and defend St. Peter the Apostle Catholic Parish, the Diocese of San Diego, its officers, directors, agents, volunteers, chaperones and representatives associated with the event with respect to any and all actions, claims, or demands that may be made or brought against the parish, the Diocese of San Diego, its officers, directors, agents, volunteers, chaperones and representatives associated with the event, arising from or in connection with my child attending this event or in connection with any illness, injury or cost of medical treatment in connection therewith. I agree to compensate the parish, the Diocese of San Diego, its officers, directors, agents, volunteers, chaperones and representatives 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 his/her health.

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 grant permission to transport my child to a hospital for emergency medical or surgical treatment. I wish to be advised prior to any further treatment administered by the hospital or doctor. In the event of an emergency, if you are unable to reach me at the above numbers, please contact:

NAME & RELATIONSHIP: _____ PHONE: (____) _____ HOME/MOBILE

FAMILY DOCTOR: _____ PHONE: (____) _____

FAMILY HEALTH PLAN CARRIER: _____ POLICY NUMBER: _____

Signature _____ Date _____

OTHER MEDICAL TREATMENT: In the event it comes to the attention of the parish, the Diocese of San Diego, its officers, directors, agents, volunteers, chaperones and representatives associated with this activity that my child becomes ill with symptoms such as headache, vomiting, sore throat, fever or 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 medications necessary and such medications will be well labeled. Names of medications and concise instructions for seeing that the child takes such medications, including dosage and frequency of dosage are as follows:

Signature _____ Date _____

MEDICATIONS: CHOOSE ONE OF THE BELOW LISTINGS: (A or B)

- A) 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 is required.

Signature _____ Date _____

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

Signature _____ Date _____

SPECIFIC MEDICAL INFORMATION

The parish will take reasonable care to see that the following information will be held in confidence. If none, or does not apply, please write "None" or "N/A" in the blank space.

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

Immunizations: Date of last tetanus/diphtheria immunization: _____

Does child have a medically prescribed diet? _____

Any physical limitations? _____

Is child subject to chronic homesickness, emotional reactions to new situations, sleepwalking, bedwetting, fainting? _____

Has child recently been exposed to contagious disease or conditions such as mumps, measles, chickenpox, H1N1, etc? If so, date and disease or condition: _____

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

PHOTO/VIDEO RELEASE

I, _____ (parent/guardian) authorize St. Peter the Apostle Catholic Parish its representatives, or volunteers, to photograph or record on audio or video (tape or digital) _____ (name of youth) for purposes of furthering the mission of St. Peter the Apostle Catholic Parish Youth Ministry, in this specific case, the creation of publication materials for youth who participate in this event on Oct. 15, 2011 (date). Photos, audio or video may be used in printed materials and any other visual display or media. I understand that such photos and/or video recordings will be used for St. Peter the Apostle Catholic Parish Youth Ministry related purposes and will not be used for any commercial purpose whatsoever. I therefore hereby waive any kind and all rights I may have for remuneration of any kind that could otherwise accrue for the uses of such photos and/or audio or video recordings.

Signature _____ Date _____