Catholic Diocese of Fort Worth and/or the Parish of

_____

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

Youth Participant's Name:_____
Birth Date:_____Sex:_____
☐Parent☐Guardian☐Conservator Name:_____
Home Address:_____
City:_____State:_____Zip:_____
Home Phone: _____Business Phone:_____
Emergency Contact Name:_____
Relationship to the son/daughter/participant:_____
Home Phone: _____ Cell Phone: _____
Texting: Yes☐ No☐Business Phone:_____

Release/Indemnification Information:
I, _____ grant my permission for_____
Parent/Guardian/Conservator's Name *Participant's Name*

*to participate with the various programs and activities of the Diocese of Fort Worth and/or the parish of _____ beginning the **1st day of June, 2012** and continuing through the **31th day of May, 2013**. These various programs and activities will take place under the guidance and direction of employees and/or volunteers from the parish of_____ and/or the Diocese of Fort Worth. 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 Fort Worth and/or parish of _____. A separate FORM B Consent to Participate and Consent to 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 Fort Worth, 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's/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: The Catholic Center, 800 West Loop 820 South, Fort Worth, TX 76108, ATTN: Director of Youth Ministry and Adolescent Catechesis) in which my son/daughter may appear by the Diocese of Fort Worth. I understand that these materials are being used for promotion of the youth ministry of the Diocese of Fort Worth which may include recruitment and fundraising efforts.

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

Social Media Release

I give permission for youth ministry leaders to communicate with my son/daughter using texting, Facebook, email, and other social media. I understand that I may request access to the social media sites, texting and any other electronic communication at any time.

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

Participant Medical Information: ***Please attach a photocopy of your (participant's) Insurance Card*** *(front and back) and fill out the information below.*

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

Insurance Carrier:_____ Policy Number:_____

Insurance ID Number:_____

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

☐ **1.** This child takes no medication and will bring no medication with him/her.

☐ **2.** This child takes medication/s and will self-medicate. The child 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 this child at the frequencies/times listed below. I understand that the adult to whom this child surrenders the medication has no medical training and this adult will not measure dosages. This child will return the medication(s) to the adult after he/she self-medicates. At the conclusion of the event it will be this child's 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**. This child takes medication but is unable to self-medicate. The child's 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 nonprescription may be administered to this child unless the situation is life-threatening and emergency treatment is required.

☐ **B.** I grant permission for the following nonprescription medication to be given to this child (excluding medication listed below that causes allergic reaction).

Non-aspirin pain reliever: Yes☐ No☐ # of tablets per dosage_____
Throat Lozenge: Yes☐ No☐
Decongestant: Yes☐ No☐ # of tablets per dosage_____
Antacid: Yes☐ No☐
Antihistamine: Yes☐ No☐ # of tablets per dosage_____

Specific Medical Information:

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

_____
Immunizations: date of last tetanus/diphtheria immunization

_____
Other medications child currently takes

_____
Any physical limitations

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

_____
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.

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