

**DIOCESE OF VICTORIA IN TEXAS
PERMISSION FORM/MEDICAL RELEASE**

NAME _____ Gender _____ Grade _____
Address _____ City _____
St/Zip _____ Phone (____) _____
Age _____ Birthdate _____ Parish _____

PARENT/LEGAL GUARDIAN'S NAME _____
Address (if different than above) _____
Phone (____) _____ Cell (____) _____ Wk (____) _____

I request and give my consent for my son/daughter, _____ to participant in D-Week, June 22-25, 2015 sponsored by NET Ministries and the Diocese of Victoria that will be held at the Spiritual Renewal Center. I understand that my son/daughter will be under the supervision of diocesan and/or NET Ministries personnel. As parent or legal guardian, I agree to defend, indemnify and hold harmless the Diocese of Victoria, its clergy, officers, agents, employees and volunteers from any claims, costs or expenses for property damages, personal injuries or other damages arising out of my son/daughter's participation in the above mentioned activity or during the transportation to and from the event. I grant permission for non-prescriptive medication (e.g. tylenol, throat lozenges, cough syrup, pepto-bismol, etc.) and routine nonsurgical medical care to be given to my son/daughter if deemed advisable by the supervising diocesan personnel. In case of an emergency, I also grant permission to transport my child to the nearest hospital for emergency medical or surgical treatment and for an authorized adult sponsor to sign for treatment if I cannot be located. I hereby give permission for my son/daughter to be photographed or video taped. I realize that the photo maybe published in the newspaper, a magazine, or other publication. The video may be used for educational purposes or informational purposes regarding programs or curriculum.

_____ Date _____ Parent's Signature _____

Family Physician _____ Phone (____) _____
Address _____ City/State/Zip _____

My son/daughter is allergic to: _____

My son/daughter takes the following medication (name, dosage): _____

This medication is for: _____ Medication that my son/daughter is allergic to: _____
Last immunization/booster for Diphtheria/Tetanus: _____

Any specific medical problems: _____ Any physical limitations: _____

In an emergency, if unable to reach parent/guardian, please contact:

Name _____ Work Phone (____) _____ Home Phone (____) _____

Name _____ Work Phone (____) _____ Home Phone (____) _____

Name of Insurance Company _____ Phone (____) _____

Address _____

City/St/Zip _____

Name of Insured _____ Policy # _____

Group or Plan # _____