

St. John the Baptist Youth Ministry Permission Slip

Jody Engebos 737-7357 w/questions face book : St. John the Baptist –Howard WI youth

EVENT INFORMATION:

Check all event(s) may attend: *(subject to change please call Jody 737-7357)*

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GENERAL INFORMATION:

Sex: Male Female

Participants Name _____ Birth date _____

Parent/Guardian's Name _____

Home Address _____

City _____ State _____ Zip code _____

Phone (____) _____ Business Phone (____) _____

Cell Phone (____) _____ Email: _____

EMERGENCY CONTACT INFORMATION: *(other than parent/guardian)*

Name _____ Relationship _____

Address _____

City _____ State _____ Zip code _____

Home Phone (____) _____ Cell Phone (____) _____

I, _____, request that the parish allow my son/daughter _____ to participate in this parish activity. This activity will take place under the guidance and direction of the Youth Ministry leaders and volunteers from St. John the Baptist Church.

I give permission to use my daughter's/son's name, picture, and voice in the parish bulletin, Youth Ministry newsletters and fliers.

Signature _____ **Date** _____

As a parent and/or legal guardian, I remain legally responsible for any personal actions taken by the above minor (participant). I agree on behalf of myself, my child named herein, or our heirs, successors, and assigns, to hold harmless and defend St. John the Baptist Church, its officers, directors and agents, and the Catholic Diocese of Green Bay, chaperones, or representatives associated with the activity for reasonable attorney's fees and expenses arising in connection therewith.

Signature _____ **Date** _____

OVER Please →

PARENTAL/GUARDIAN CONSENT FORM AND LIABILITY WAIVER

MEDICAL MATTERS: I hereby warrant that 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 that are applicable.)

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. In the event of an emergency, if you are unable to reach me at the provided numbers, contact the emergency contact listed.

Family doctor: _____ Phone: _____
Family Health Plan Carrier: _____ Policy #: _____
Signature: _____ **Date:** _____

Other Medical Treatment: In the event it comes to the attention of the parish, its officers, directors and agents, and the Catholic Diocese of Green Bay, coaches, chaperons, or representatives associated with the activity that my child becomes ill with symptoms such as **headache, vomiting, sore throat, fever, diarrhea**, I want to be called.

Signature: _____ **Date:** _____

Medications: 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 such medications, including dosage and frequency of dosage, are as follows:

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 is required.

Signature: _____ **Date:** _____

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

Signature: _____ **Date:** _____

Specific Medical Information: The parish will take reasonable care to see that the following information will be held in confidence. Allergic reactions (medications, foods, plants, insects, etc.):

Immunizations: Date of last tetanus/diphtheria immunization: _____

Does child have a medically prescribed diet? _____

Any physical limitations? _____

Has child recently been exposed to contagious disease or conditions, 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:

Signature _____ **Date** _____