Archdiocese of Galveston-Houston / St. Anne Catholic Church

PARENTAL/GUARDIAN CONSENT, LIABILITY WAIVER AND MEDICAL CONSENT

Participant's Name________________________________**Date of Birth** ________________________

Home Address____

City ____ **Zip Code**____________________________

Parent/Guardian ______________________________ **Home Phone** (___)___________________

Alternate Phone Number: (___)____________________ ☐☐**Cell Phone** **or** ☐☐**Pager**

Parish ____________St. Anne's Catholic Church______ **Grade** ______ **Age** _______ **Sex**___

Teen's E-Mail__________________________________ **T-shirt size** ____________

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) ______Texas Rally For Life__to be held Saturday, January 27, 2018 (time) __8:30am-6:30pm_______, and (location) ____Austin, TX

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, to hold harmless and defend the Archdiocese of Galveston-Houston, St. Anne Catholic Church (its pastor, employees, other agents, etc.), the sponsoring parish (its pastor, employees, other agents, etc.) or any representatives associated with the scheduled activity unless the parties involved were careless or negligent.

____ ____________________
Signature (Parent/Guardian) **Date**

____ ____________________
Signature (Participant 18 years of age or older must sign own consent) **Date**

PHOTOGRAPHY CONSENT

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

____ ____________________
Signature (Parent/Guardian) **Date**

Developed by the Office of Youth Ministry – Archdiocese of Galveston-Houston
Revised for St. Anne Catholic Church – 6/23/10

MEDICAL CONSENT

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.
In the even 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 frequency 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 nonprescription 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: ________________________________
____

Insurance Information

(Please attach a copy of the Insurance Card, front and back, with this form)

☐ ☐ 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 it comes to the attention of the chaperones associated with the activity that my child becomes ill with repeated symptoms such as headache, vomiting, sore throat, fever, diarrhea, I want to be called immediately. If this will be a long distance call, I want to be called collect (with phone charges reversed to myself).

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**