

OFFICE OF YOUTH MINISTRY AND YOUNG ADULT MINISTRY
ST. ANTHONY OF PADUA AND 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 all church sponsored activities from _____ September 2014 _____ through _____ May 2015 _____, sponsored by _____ St. Anthony of Padua, Palacios, TX _____ and/or by the Diocese of Victoria. I understand that my son/daughter will be under the supervision of diocesan and/or parish personnel. As parent or legal guardian I agree to defend, indemnify and hold harmless the Diocese of Victoria and _____ St. Anthony's _____, 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 # _____