

**CATHOLIC DIOCESE OF SIOUX FALLS OVERNIGHT YOUTH EVENT
PARENTAL/GUARDIAN CONSENT FORM AND LIABILITY WAIVER**

Participant's Name: _____ School Attending _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Gender: _____ T- shirt size: _____ Birth Date: _____ Age: _____

Parish & City: _____

Parent/Guardian/Name: _____

Home phone: _____ Work phone: _____

I, _____, grant permission for my child, _____

Parent or Guardian's Name

Child's Name

To participate in this parish youth ministry event that requires transportation to a location away from the parish site. This activity will take place under the guidance and direction of parish employees and/or volunteers from _____

Parish Name

I agree on behalf of myself, my child named herein, or our heirs, successors, and assigns, to hold harmless and defend _____, its officers, directors and agents,

(Name of Parish)

and the Catholic Diocese of Sioux Falls, chaperones, or representatives associated with the event, arising from or in connection with my child attending the event or in connection with any illness or injury or cost of medical treatment in connection therewith, and I agree to compensate the parish, its officers, directors and agents, and the Catholic Diocese of Sioux Falls, chaperones, or representative associated with the event for reasonable attorney's fees and expenses arising in connection therewith.

Signature: _____ Date: _____

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 above numbers, contact:

Name and Relationship to participant: _____ Phone: _____

Family Doctor: _____ Phone: _____

Health Plan Carrier: _____ Policy #: _____

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 tylenol, ibuprofen, motrin, 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 the child have a medically prescribed diet? _____

Any physical limitations? _____

Is child subject to chronic homesickness, emotional reactions to new situations, sleepwalking, fainting _____

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: _____
