

OFFICE OF YOUTH MINISTRY AND YOUNG ADULT MINISTRY
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 \_\_\_\_\_ through \_\_\_\_\_, sponsored by \_\_\_\_\_ 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 \_\_\_\_\_, 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 # \_\_\_\_\_