

**University of Dallas, Catholic Pro-Life Committee and Catholic Diocese of Fort Worth
Annual Youth Ministry Parent/Guardian/Conservator Permission, Liability Waiver and Medical Information**

Youth Participant's Name: _____
Birth Date: _____ Sex: _____
___ Parent ___ Guardian ___ Conservator Name: _____
Home Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Business Phone: _____
Emergency Contact Name: _____
Relationship to the son/daughter/participant: _____
Home Phone: _____ Cell Phone: _____
Texting: Yes No Business Phone: _____

Release/Indemnification Information:

I, _____ grant permission for my child, _____
Parent or guardian's name Participant's Name
to participate in the below described parish event. This activity will take place under the guidance and direction of Youth for Life. A brief description of the activity follows:

Description of event: Pro-Life Boot Camp
Date of event: Session 1 July 1-3, 2011 and/or Session 2 July 29-Aug 2, 2011
Destination of event: University of Dallas Irving, Tx
Individual(s) in charge: _____ Sue Laux / _____ Jacquelyn Smith
Transportation to/from event is the responsibility of the participant

During this event, I give permission for either of the adults named above in charge of the event to consent to emergency medical or surgical treatment for _____
Name of minor

I understand that as parent/guardian/conservator, I remain legally responsible for any personal actions taken by the participant named above.

I agree on behalf of myself, my son/daughter/participant named herein, our/his/her heirs, successors, and assigns to hold harmless, the University of Dallas, the Catholic Pro-Life Committee, the Diocese of Fort Worth, the Bishop and his successors, employees, agents, volunteers, the Parish, its employees and volunteers from any and all claims (unless due in part by gross negligence of the Diocese and/or Parish) for illness, injury, death and the cost of medical treatment therewith, arising from or in any way connected with my son's/daughter/participant's attending the various programs and activities during the dates named above.

In the event any legal action is taken by either party against the other party to enforce any of the terms and conditions of this agreement, it is agreed that the unsuccessful party to such action shall pay to the prevailing party therein all reasonable court costs, reasonable attorneys' fees and expenses incurred by the prevailing party.

Promotional Release

I also consent to the use of any videotapes, photographs, slides, audiotapes, or any other visual or audio reproduction (in perpetuity unless otherwise revoked by me in writing and delivered by certified mail, return receipt requested, to: The Catholic Center, 800 West Loop 820 South, Fort Worth, TX 76108, ATTN: Director of Youth Ministry and Adolescent Catechesis) in which my son/daughter may appear by the Diocese of Fort Worth the University of Dallas or the Catholic Pro-Life Committee. I understand that these materials are being used for promotion of the youth ministry of the Diocese of Fort Worth the University of Dallas, the Catholic Pro-Life Committee which may include recruitment and fundraising efforts.

Parent/Guardian/Conservator Signature _____ Date _____

Social Media Release

I give permission for youth ministry leaders to communicate with my son/daughter using texting, Facebook, email, and other social media. I understand that I may request access to the social media sites, texting and any other electronic communication at any time.

Parent/Guardian/Conservator Signature _____ Date _____

Participant Medical Information

****Please attach a photocopy of your (participant's) Insurance Card, front and back and fill out the information below.****

Youth Participant's Name: _____

Insurance Carrier: _____ Policy Number: _____

Insurance ID Number: _____

Social Security #: _____

Medications: Check All that Apply – Note: DO NOT CHECK ALL BOXES BELOW AS ONE MAY CANCEL OUT ANOTHER

- This child takes no medication and will bring no medication with him/her.
- This child takes medication/s and will self-medicate. The child will bring all such medications necessary, and such medications will be clearly labeled. I understand that the child will be required to turn all medication(s) over to a supervising adult designated to keep medication(s). I further understand that it will be this child's responsibility to present himself/herself at a location designated for returning medication(s) to this child at the frequencies/times listed below. I understand that the adult to whom this child surrenders the medication has no medical training and this adult will not measure dosages. This child will return the medication(s) to the adult after he/she self-medicates. At the conclusion of the event it will be this child's responsibility to pick up remaining medication(s), if any, at the self-medication designated location. Names of medications and exact dosage and frequencies/times are as listed below: (you may attach a sheet to this form if you need more space just make sure to sign and date it as well).

This child takes medication but is unable to self-medicate. The child's parent/guardian/conservator will provide and dispense any and all needed medications.

No medication of any type whether prescription or nonprescription may be administered to this child unless the situation is life-threatening and emergency treatment is required.

I grant permission for the following nonprescription medication to be given to this child (excluding medication listed below that causes allergic reaction).

Non-aspirin pain reliever: Yes _____ No _____ # of tablets per dosage _____

Throat Lozenge: Yes _____ No _____

Decongestant: Yes _____ No _____ # of tablets per dosage _____ Antacid: Yes _____

No _____

Antihistamine: Yes _____ No _____ # of tablets per dosage _____

Specific Medical Information

Allergic reactions (medications, foods, plants, insects, etc.)

Immunizations: date of last tetanus/diphtheria immunization

Other Medications child currently takes

Any physical limitations

Has child recently been exposed to contagious disease or condition such as mumps, measles, chicken pox, etc.? If so, date and disease or condition.

You should also be aware of these special medical conditions of this child. Please attach a clear description to this form

Signature of Parent/Guardian/Conservator: _____

Witnessed by me, _____ this _____ day of _____

Notary's Signature: _____ Notary's Seal:

Required