2017-2018

FORM D

OFFICE OF YOUTH AND YOUNG ADULT MINISTRY
DIOCESE OF VICTORIA IN TEXAS
PERMISSION FORM/MEDICAL RELEASE

NAME_____ Sex: ☐ M or ☐ F Age _____

Address_____ City _____

St/Zip_____ Phone (____)_____

Birthdate_____Parish/City_____

I am willing to participate in the CCD program **(event), sponsored by the Office of Youth and Young Adult Ministry of the Diocese of Victoria in Texas on** Aug 1, 2017 - Aug 1, 2018 **(date).** I agree to defend, indemnify and hold harmless the Diocese of Victoria, 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 participation in the above mentioned activity.'

In case of an emergency, I grant permission and authorization for a designated adult representative of the Office of Youth and Young Adult Ministry to sign for treatment by a local physician and/or hospital selected by the Office of Youth and Young Adult Ministry of the Diocese of Victoria in Texas.

Date_____ Signature_____

Family Physician_____ Phone (_____)_____

Address_____ City/Zip_____

1. Are you allergic to any type of medication? If so, please indicate: _____

Describe reaction? _____

2. Are you presently taking any prescription medication over an extended period of time? _____

Name of medication: _____ What is it for? _____

3. Do you have any allergies? _____ If so, what are they? _____

Last immunization/booster for Diphtheria/Tetanus:_____

Name of Insurance Company_____ **Phone (____)** _____

Address_____**City/St/Zip**_____

Name of Insured_____ **Policy or Group Plan #**_____

In an emergency, if unable to reach parent/guardian, please contact:

Name _____Work Phone (_____) _____ Home Phone (_____) _____

Name _____Work Phone (_____) _____ Home Phone (_____) _____

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Revised 5/2005