OFFICE OF YOUTH MINISTRY AND YOUNG ADULT MINISTRY (2018-2019)
ASSUMPTION OF THE BLESSED VIRGIN MARY CHURCH / DIOCESE OF VICTORIA IN TEXAS
PERMISSION FORM/MEDICAL RELEASE

NAME______________________________ Gender_______ Grade__________
Address______________________________ City ______________________
State/Zip____________________ Phone (________)__________________
Age __________ Date of Birth________________ Parish: Assumption of the Blessed Virgin Mary - Ganado

PARENT/LEGAL GUARDIAN'S NAME______________________________
Address (if different than above)______________________________
Phone (______)________________ Cell (______)________________ Work(_______)______________

I request and give my consent for my son/daughter, ____________________ to participate in all church sponsored activities from August 1, 2018 through August 31, 2019 **sponsored by Assumption of the Blessed Virgin Mary Church** 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 Assumption of the Blessed Virgin Mary Church, 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.

__________*(please initial for consent)* Photo Disclaimer: I hereby give permission for my son/daughter to be photographed or video taped. I realize that the photo may be 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 #______________________________