Saint George Parish
Forty Brattle Street Worcester, Massachusetts 01606-2599
508-853-0183

Confirmation Program Release and Consent

~ Please Print ~

Candidate name: _____ Birth date: _____ Age: _____
Name of Parent(s)/Guardians:_____
Address: _____
Home phone: _____ Emergency Phone: _____

I, _____ (parent/legal guardian), the undersigned, give my permission for my son / daughter, _____, to participate in St. George Parish Confirmation Program and Service Experiences. These activities will take place under the guidance of an individual(s) who has completed a CORI for the Diocese of Worcester.

While youth are responsible for their own behavior, as parent and /or legal guardian, I remain legally liable for any actions or damages made by my child. I have instructed the above named minor to be respectful toward all adult leaders and to conduct themselves in a Christian manner.

I hereby warrant to the best of my knowledge, my child is in good health and I assume all responsibility for the health of my child. In the event of medical emergency and if I (or other below named guardian) cannot be reached, I hereby give permission to transport my child to a hospital or medical facility and to seek medical attention. In case of emergency, please contact (Please list primary guardians and one alternate contact.):

1. Name _____Phone_____
2. Name _____Phone _____
3. Name_____ Phone_____

In the event of **urgent medical emergency** and if none of the above named contacts can be reached, I authorize the necessary medical treatment to be administered by qualified medical personnel for the benefit of my son /daughter. I relieve the Diocese of Worcester, a Corporation Sole, and St. George's Parish of all responsibility and consequences that may arise as a result of this treatment. I will not hold the Diocese or their associated representatives responsible in the event of injury. I also agree to accept all financial responsibility as a result of scheduling such treatment.
The following medical information must be completed:

Insurance Company _____
Group # _____
Subscriber's Name _____
Subscriber's # _____
Employer _____

Date of last tetanus shot _____
Allergies _____
Medications currently taking (name & dosage)
_____
You should also be aware of these special medical / physical / mental conditions of my child:
_____

I have read the Program Guidelines attached to this form (initial & circle please) Yes _____

I give my permission to include my child in photos (see next pg. - circle one response please) Yes No

_____ _____
Parent/Guardian's Signature Date