This form is to be used for all young people through age 18.

FORM A

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 participate 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 #____