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 #____