VACATION BIBLE SCHOOL 2019 VOLUNTEER

FOR YOUTH entering 7th Grade or Older, and for ADULTS

Queen of the Holy Rosary Parish, Hostyn & Sts. Peter & Paul Parish, Plum
936 FM 2436 La Grange, TX 78945 hostynch@cvctx.com 979-247-4441 FAX 979-247-5008

Hostyn Parish Hall July 8-12, 2019 Volunteer's hours approx. 7:30am-12:30pm

DAYS AVAILABLE: ____MON. ___TUE. ___WED. ___THURS. ___ FRI.

TEEN VOLUNTEER NAME: _____ AGE: _____ GRADE: _____

OR ADULT VOLUNTEER NAME: _____

Address _____

Phone _____ Email _____

I have completed the Diocese of Victoria Safe Environment Training and Background Check _____Yes _____No

Photo Disclaimer: I hereby give permission for my son/daughter, or for myself, to be photographed or videotaped. I realize that the photo may be published in a newsletter or other publications, on the parish website, or parish bulletin boards. The photos/video may be used for educational or informational purposes regarding the programs at the Diocese of Victoria and its Parishes.

PERMISSION FORM/VEHICLE/MEDICAL RELEASE

I hereby consent to participation by myself, or my son/daughter, in VBS sponsored by Queen of the Holy Rosary Catholic Church & Sts. Peter & Paul Catholic Church of the Diocese of Victoria. I understand that my son/daughter will be under the supervision of diocesan and parish personnel. As parent or legal guardian I agree to defend, indemnify and hold harmless the Diocese or Queen of the Holy Rosary Catholic Church & Sts. Peter & Paul Catholic 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, or my son/daughter's, participation in these activities.

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 myself, or my son/daughter if deemed advisable by the supervising personnel. I understand that all meds will be collected and disbursed by an adult staff member. (No meds should be in the possession of youth participants with the exception of inhalers.) In case of an emergency, I also grant permission to transport me, or 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 or I am unable to sign for myself.

KNOWN ALLERGIES (to FOOD or to DRUGS) **OR OTHER MEDICAL CONCERNS/PHYSICAL LIMITATIONS**: _____

_____

Current medication(s) - name and dosage:_____

This medication is for:_____

Last immunization/booster for Diphtheria/Tetanus:_____

Family Physician _____ Phone (_____)_____

Address _____

Name of Insurance Company: _____ Phone (_____)_____

Name of Insured _____ Policy/Group # _____

Emergency Contact Person / Telephone: _____ _____

Emergency Contact Person / Telephone: _____ _____

Signature of Volunteer: _____ Date: _____

Signature of Parent/Guardian if volunteer is under 18 _____ Date:_____