ROMAN CATHOLIC DIOCESE OF ROCHESTER

MEDICAL CONSENT, PERMISSION AND RELEASE FORM

I, _____, the parent or legal guardian of _____

(Name of Parent/Guardian) (Name of Youth)

authorize the employees, representative and chaperones of St. Katharine Drexel parish to obtain emergency medical treatment, should it be necessary, during my child's attendance and participation in St. Katharine Drexel Faith Formation, in the 2019 - 2020 academic year.

(Activity/Program)

I understand that I will be notified immediately should it become necessary to obtain emergency treatment. The person(s) who should be notified and the telephone number(s) are:

Name_____ Phone Number_____

Name_____ Phone Number_____

I consent and give permission for my child's participation and attendance in this activity/program. In consideration of my child's attendance and participation, I hereby, for myself, my heirs, executors, administrators and assigns, waive and release any and all claims for damages I may have against St. Katharine Drexel Parish, the Roman Catholic Diocese of Rochester, New York, their representatives, chaperones, employees, successors and assigns arising out of any and all injuries by my child while participation in this activity/program.

Date ____/____/____ Signature_____

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As a youth of St. Katharine Drexel Parish, I understand and agree to follow the rules and regulations as determined by the Parish, and the Diocese of Rochester for this activity/program. I also understand and agree that I will notify my parent or guardian at the time of any violations requiring my dismissal from the program/activity and that I will be sent home at my own and/or parent's/guardian's expense.

Parent/Guardian

Signature _____

Date ____/____/____

Youth Participant

Signature _____

Date ____/____/____

X

ROMAN CATHOLIC DIOCESE OF ROCHESTER

HEALTH FORM

Name of Pariticipant_____ Phone_____

Address_____

Town/City_____ Zip_____

Date of Birth_____

Parish/Location _____

Emergency Contact_____ Phone_____

Health Insurance Company_____ Policy No._____

Family Physician/Clinic_____ Phone _____

Please list any allergies or special needs.

_____

_____

_____

Is there anything else we should know about your child?

_____

_____

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In signing this health form, I hereby certify that the above information is correct and give permission for my child to be transported in privately owned vehicles for medical and other emergency purposes only and for the release of medical records to an attending physician in case of illness.

In case of medication emergency, I understand that every effort will be made to contact the parents or guardian. In the event that I cannot be reached, I hereby give permission to the physician selected to secure proper treatment for my child named herein.

Signature of parent/guardian_____

Phone Number_____ Date_____