

# Diocese of Orlando

## OFFICE OF YOUTH YOUNG ADULT MINISTRY

**PARENTAL GUARDIAN CONSENT FORM, LIABILITY WAIVER MEDICAL CONSENT** Transportation not Provided

*please PRINT legibly*

**Youth Participant's Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_  
**Address** \_\_\_\_\_ **City/State/Zip** \_\_\_\_\_  
**Home Phone:** \_\_\_\_\_ **Male** **Female** (←please circle→) **T-Shirt Size:** S M L XL XXL XXXL  
**Parent/Guardian's Name:** \_\_\_\_\_ **Cell Phone:** \_\_\_\_\_ **Work Phone:** \_\_\_\_\_  
**Other number where Parent/Guardian can be reached during event:** \_\_\_\_\_  
**Emergency Contact Name:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

### CONSENT & LIABILITY WAIVER

**Important! To be filled out by the Parent/Guardian for youth under 18 years of age & individuals age 18 or older and in high school. Individuals age 18 or older and still in high school must also complete and submit a ADULT MEDICAL RELEASE AND LIABILITY WAIVER as well.**

In consideration of the program in which my son/daughter will participate, I as parent or guardian of my son/daughter, do hereby agree to allow my son/daughter to accompany Resurrection Youth Ministry's program to:

**Event & Location:** Wait For Me

**Date & Time:** Saturday, February 4th, 2012 beginning at 9 a.m. and ending at 8:30 p.m..

**Method of Transportation:** transportation provided by family

I acknowledge receipt of the attached information sheet describing the planned activities.

I acknowledge that Church of the Resurrection is not providing transportation from the Church's property to and from the event. My child must comply with Church of the Resurrection's rules and procedures. By granting this permission, I also waive any claims against, and RELEASE AND HOLD HARMLESS AND INDEMNIFY, Church of the Resurrection, the Diocese of Orlando, and any of their religious, employees, volunteers, agents and representatives from any liability, claims, demands and causes of action arising out of or relating to any loss, damage or injury sustained in connection with or arising out of my child's participation in the program.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

**YOUTH PARTICIPANT:** In signing the line below I agree to abide by any/all policies established for this event/activity. Should I not be able to maintain the guidelines and expectations of the adults and my peers, I understand that there will be consequences for my actions, including being removed from the activity and being sent home at my parent/guardian's expense.

\_\_\_\_\_  
Youth Participant's Signature

\_\_\_\_\_  
Date

### VIDEO/PHOTOGRAPHY CONSENT

Parents/guardians of participants are advised that photographs or videotape of participants may be used in publications, websites or other materials produced from time to time by the Office of Youth and Young Adult Ministry &/or the Diocese of Orlando. (Participants would not be identified, however, without specific written consent.) Please note that the Office has no control over the use of photographs or film taken by media that may be covering the event in which your child(ren) participate(s).

I hereby expressly assign to the Diocese of Orlando, and to all its agents all the rights, title and interest in, and to all photos/videotape recordings made by such in which my child appears and/or his/her voice is used in and in connection with the videotaping of this event. I hereby authorize the reproduction, sale, lease, copyright, exhibition, broadcast and/or any distribution of said photos/videotape without limitation for any purpose whatsoever; and I further waive all rights to any compensation for my child's appearance or participation in the photographs/videotape recordings.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

*(continued on back-Please complete BOTH sides of this form)*

09/2009

# Diocese of Orlando

## OFFICE OF YOUTH YOUNG ADULT MINISTRY

### PARENTAL/GUARDIAN CONSENT FORM, LIABILITY WAIVER MEDICAL CONSENT

*please PRINT legibly*

#### Medical Matters

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. Of the following statements pertaining to medical matters, sign/initial only those in accordance with your wishes:

#### Emergency Medical Treatment

In the event of an emergency, I hereby give permission to transport my child to a hospital/clinic for emergency medical or surgical treatment.

In the event of an emergency and you are unable to reach me, contact:

Name & Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Family Doctor \_\_\_\_\_ Phone \_\_\_\_\_

#### Medications

\_\_\_\_\_ I hereby **Grant Permission** for my child to be given the following provided medications. My child will bring all such medications, well labeled. [NOTE: Any/all prescription medications must be in original pharmacy container with young person's name on the prescription label. Non-prescription/over-the-counter medications must be in original container with young person's name on the container.] *(Please initial)*

Names of medications and concise directions for seeing that the child takes such medications, including dosage and frequency are as follows:

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_ Administer: \_\_\_\_\_

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_ Administer: \_\_\_\_\_

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_ Administer: \_\_\_\_\_

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_ Administer: \_\_\_\_\_

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_ Administer: \_\_\_\_\_

**Medical Conditions Information:** (Diocesan personnel will take reasonable care to see that the following information will be held in confidence.)

My son/daughter:

- Is allergic to the following medications \_\_\_\_\_
- Has had an episode of the following or has been diagnosed with:  Seizures  Asthma  Diabetic
- Has had allergic reactions to the following (foods, dyes, latex, etc.) \_\_\_\_\_
- Has had a medical surgery within the last six months?  Yes  No      Still under doctor's care?  Yes  No
- Has a medically prescribed diet *(please explain)* \_\_\_\_\_
- Has the following physical limitations \_\_\_\_\_
- Immunizations current and up to date?  Yes  No      Date of last tetanus/diphtheria immunization \_\_\_\_\_
- You should also be aware of these special medical conditions of my child: \_\_\_\_\_

**Insurance Information**  No, I do not carry medical insurance at this time.

Insurance Carrier: \_\_\_\_\_ Name of Insured: \_\_\_\_\_

Insurance Policy Number: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Day Phone: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Day Phone: \_\_\_\_\_

**In the event the participant does not have insurance, payment in full for medical care becomes the responsibility of the participant's parent/guardian.**

I fully understand the foregoing statements and sign this Parental/Guardian Consent Form, Liability Waiver & Medical Consent knowingly, freely, and willingly.

Parent/Guardian Signature *(must sign for any participant under 18 &/or 18 or older & in high school)* \_\_\_\_\_

Date \_\_\_\_\_

Participant Signature *(participant 18 years of age or older must sign)* \_\_\_\_\_

Date \_\_\_\_\_