Parental/Guardian Consent Form & Liability Waiver

(This form is required for minors to attend an off property event or trip).

Applicant Information

Participant's Name & E-mail Address:			Date of Birth:
Address:	City	State:	Zip:
Home Phone:	Parent/Guardian's Name & E-mail Address:		
Cell Phone:	Work Phone:	Other number where Parent/Guardian can be reached during event:	

Consent & Liability Waiver

Important! To be filled out by the Parent/Guardian for youth under 18 years of age and individuals age 18 or older and in high school.

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 (entity name) _____ to:

Event & Location:	Date & Time:
☐ Transportation Not Provided ☐ Transportation Provided	Method of Transportation:

I acknowledge that (entity name) _____
is providing transportation to and from (location) _____ to the event.
I acknowledge and assume the risk of this transportation for my child. My child must comply with (entity name) _____ rules and procedures. By granting this permission, I also waive any claims against, and RELEASE AND HOLD HARMLESS AND INDEMNIFY, (entity name) _____, the Diocese of Orlando, 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

(must sign for any participant under 18 &/or 18 or older & in high school)

Participant: In signing the line below, I certify all the information on the trip form is complete and accurate, I also 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 there will be consequences for my actions, including being removed from the activity and being sent home at my parents/guardian's expense.

_____ _____

Participant's Signature — Date

Insurance Information

☐ No, I do not carry medical insurance at this time. ☐ I do 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.

Parental/Guardian Medical Information & Consent Form

Applicant Information

Participant's Name:			Date of Birth:	
Address:	City:	State:	Zip:	Phone:
Father's Name:	Phone:			
Mother's Name:	Phone:			
Emergency Contact:	Languages Spoken by Emergency Contact:			

Medical Matters

I hereby warrant to the best of my knowledge, all the information provided is true and correct and I assume all responsibility for the health of my child. I understand it is my responsibility to update the Medical Information & Consent Form if there are any changes to my child's health. (*Please initial)* _____

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. (*Please initial)* _____

Family Doctor:	Phone:

Medications: I hereby **Grant Permission** for my child to be given the following provided medications. All medications must be 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.] I release and hold harmless (entity name) _____, the Diocese of Orlando and any other religious, employees, volunteers, agents and representatives from any injury or harm resulting from administering the medication. (*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:

Medical Conditions Information: (Reasonable steps will be taken to keep this information confidential, but it will be shared with Diocesan personnel and others, as warranted.) 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. ☐ I do carry medical insurance at this time.	Insurance Carrier:
Name of Insured:	Insurance Policy Number:

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

_____ _____

Parent/Guardian Signature Date

(must sign for any participant under 18 or 18 or older & in high school)