



**Diocese of Laredo
St. Patrick Church**

PARENTAL/GUARDIAN CONSENT FORM AND LIABILITY WAIVER

Name: _____ **Birth Date:** _____

Parish: _____ **Grade:** _____ **Age:** _____ **Sex:** _____

Address: _____ **City:** _____ **Zip:** _____

Parent/ Guardian: _____ **Phone:** (____) _____

Consent & Liability Waiver

I, (Parent/Guardian) _____, **grant permission for my child,**
(Participant's Name) _____, **to participate in**
(Event) _____, **to be held (Day & Date)** _____ **(Time)**
_____, **(Location)** _____ **Mode of**
transportation: _____ **I agree on**
behalf of myself, and my child name herein, or our heirs, successors, and assigns, to hold harmless and
defend the DIOCESE OF LAREDO, the sponsoring parish, it's pastor, youth minister, parish volunteers and
other agents, etc. or any representatives associated with the scheduled activity or in connection with any
illness or injury (including death) or cost of medical treatment and I agree to compensate the DIOCESE OF
LAREDO, the sponsoring parish (it's pastor, Youth Minister, parish volunteers, and other agents, etc.) or
any representatives associated with the event for reasonable attorney's fees and expenses which they may
incur in any action brought against them as a result of such injury or damage.

Signature

Date

Photography Consent

I understand that promotional pictures (individual and group) will be taken during this event. I give permission for my son's or daughter's pictures to be used for promotional materials (newsletter, newspaper, media, etc.) in highlighting the event.

Signature

Date

MEDICAL CONSENT

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 only in accordance with your wishes:

In the event of any emergency, I hereby give permission to transport my child to a hospital for emergency medical or surgical treatment. I wish to be advised prior to any further treatment by the hospital or doctor.

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

Name & Relationship _____ Phone: (____) _____

Family Doctor _____ Phone: (____) _____

Medications

My child will bring needed medications, well labeled, and concise directions for such medications, including dosage and frequency.

My child is taking the following medication at the present time.

Medication(s): _____ Dosage: _____
_____ Dosage: _____

_____: I hereby **Do Not Grant Permission** for medication of any type, whether prescription or nonprescription may be administered to my child unless the situation is life threatening and emergency treatment is required. (Please initial)

_____: I hereby **Grant Permission** for nonprescription medication (such as Tylenol, throat lozenges, cough syrup) to be given to my child if deemed advisable. I understand that Aspirin will not be given to my son/daughter. (Please initial)

Medical Conditions Information

(Diocesan personnel will take reasonable care to see that the following information will be held in confidence.)

Has had an episode the following or has been diagnosed: ☐ Seizures ☐ Asthma ☐ Diabetic

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? _____

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

(Please attach a copy of the Insurance Card, front and back, with this form)

Insurance Carrier: _____

Name of Insured: _____

Insurance ID Number: _____ Insurance Policy Number: _____

Father's Name _____ Birth Date _____

Place of Employment: _____ Phone Number: _____

Mother's Name: _____ Birth Date: _____

Place of Employment: _____ Phone Number: _____

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

In the event it comes to the attention of the chaperones associated with the activity that my son/daughter becomes ill with repeated symptoms such as headache, vomiting, sore throat, fever, diarrhea, I want to be called immediately, if this will be a long distance call, I want to be called collect (with phone charges reversed to myself).

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

Signature (Parent/Guardian) must sign for anyone under 18 year of age

Date