Our Lady of the Assumption Religious Education Registration form

OLOA 2022-2023 **YOUTH REGISTRATION, CONSENT, LIABILITY WAIVER** _____

Last Name

Diocese of Beaumont

PLEASE PRINT OR TYPE

NAME_____SEX:_____Male_____Female
Last First Middle

ADDRESS_____PHONE _____
P.O. Box or Street City State Zip

Name **Address** **Phone/Mobile Phone, etc.**

Mother _____

Father _____

LIST TWO NEIGHBORS OR RELATIVES WHO WILL ASSUME TEMPORARY CARE OF YOUR CHILD IF YOU CANNOT BE REACHED.

Name_____ Name _____

Address_____Tel_____Address_____Tel _____

Note any health conditions such as heart disease, diabetes, eye or ear problems, epilepsy, severe allergies, chronic ailments, etc.
Explanation:

_____

_____

RELIGION_____CHURCH YOU ATTEND _____

GRADE (Fall 20__) _____AGE_____DATE OF BIRTH_____PLACE OF BIRTH _____

Name of school attending this year: _____ School attended last year: _____

I/WE THE PARENT(S) GUARDIAN(S) OF THE ABOVE NAMED INDIVIDUAL HEREBY GIVE MY/OUR CONSENT AND APPROVAL FOR HIS/HER PARTICIPATION IN ANY AND ALL ACTIVITIES SPONSORED BY THE DIOCESE OF BEAUMONT, MOST REVEREND DAVID L. TOUPS, BISHOP OF DIOCESE OF BEAUMONT, AND/OR THIS PARISH AND/OR THIS SCHOOL, AND ANY AND ALL ORGANIZERS OR SPONSORS, INCLUDING PARTICIPATION IN ATHLETIC EVENTS. I/WE ASSUME ALL RISKS AND HAZARDS INCIDENT TO THE CONDUCT OF SUCH ACTIVITIES, INCLUDING ANY AND ALL TRANSPORTATION, AND FOR AND IN CONSIDERATION OF THE EDUCATIONAL INSTRUCTION HE/ SHE WILL RECEIVE IN CONNECTION THEREWITH, I/WE HEREBY AGREE TO RELEASE, ABSOLVE, INDEMNIFY AND HOLD HARMLESS, AND DO BY THIS INSTRUMENT RELEASE, ABSOLVE, INDEMNIFY AND HOLD HARMLESS THE DIOCESE OF BEAUMONT, MOST REVEREND DAVID L. TOUPS, BISHOP OF DIOCESE OF BEAUMONT, AND/OR THIS PARISH AND/OR THIS SCHOOL, AND ANY AND ALL ORGANIZERS OR SPONSORS, OF AND FROM ANY AND ALL LIABILITY FOR AN INJURY TO MY/OUR AFORESAID YOUTH, AND I/WE WAIVE ALL CLAIMS OF ANY KIND AGAINST ANY OR ALL OF THE ORGANIZATIONS OR PERSONS HEREINABOVE ENUMERATED, INCLUDING ANY AND ALL CLAIMS AGAINST ANY PERSONS TRANSPORTING MY/OUR CHILD TO OR FROM ANY SUCH ACTIVITIES HEREINABOVE NAMED. I WE AUTHORIZE THE PARISH AND/OR SCHOOL AND ANY AND ALL ORGANIZERS OR SPONSORS TO PERFORM A PRE-BOARDING SEARCH OF OUR SON'S/DAUGHTER'S LUGGAGE AND/OR BACKPACK AND/OR PURSE FOR ILLEGAL SUBSTANCES OR ANY ITEM WHICH MAY ENDANGER THE HEALTH OR SAFETY OF THE ORGANIZATION, ITS PARTICIPANTS OR PERSONNEL. I/WE AUTHORIZE THE PARISH AND/OR SCHOOL AND ANY AND ALL ORGANIZERS OR SPONSORS TO PERFORM A SEARCH UPON OUR SON/DAUGHTER IF HE/SHE IS SUSPECTED TO BE IN POSSESSION OF ILLEGAL SUBSTANCES OR ANY ITEM WHICH MAY ENDANGER THE HEALTH OR SAFETY OF THE ORGANIZATION, ITS PARTICIPANTS, OR PERSONNEL.

Date _____ Father's Signature _____

Mother's Signature _____

MUST BE SIGNED BY PARENTS OR GUARDIANS
REVERSE SIDE OF FORM MUST BE COMPLETED

I give permission for my son/daughter to attend and participate in events sponsored by this particular parish and/or this school and/or Diocese of Beaumont.

*E-Mail Address: _____

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Please fill in ALL blanks below. If the answer is none or does not apply, write none or N/A in that blank. Every line needs response

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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, mark 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 for emergency medical or surgical treatment. I wish to be advised prior to any further treatment by the hospital or doctor and I understand that all financial obligations are my responsibility.

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 all such medications, well labeled, that are necessary. Names of medications and concise directions for seeing that the child takes such medications, including dosage and frequency are as follows:
My child is taking the following medication at the present time.
Medication(s):_____Dosage:_____
Administer: _____

____ I hereby **Do Not Grant Permission** for medication of any type, whether prescription or nonprescription may be administered by 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.)

My son/daughter has:
Has had an episode of the following or has been diagnosed: Seizures Asthma Diabetic (Circle all that apply)
Allergic reactions to the following (food, dyes, latex etc.) _____
Has a medically prescribed diet? _____
The following physical limitations? _____
Immunizations current and up to date: Yes No (Please circle) Date of last tetanus/diphtheria immunization _____
You should also be aware of these special medical conditions of my child (e.g. depression, anxiety, etc.):
_____

_____

_____
Parent(s) or Guardian(s) Signatures Date Signed

Insurance Company: _____
Information

Policy Carrier (Name Employer or Individual): _____

Policy Number: _____

Video/Photography Consent

As parent/guardian, I understand that promotional pictures and videos (individual and group) will be taken during diocesan events. I give permission for my son's/daughter's picture to be used for promotional materials (newsletter, web page, calendars, power point, video etc.) in highlighting diocesan events.

_____ _____
Signature (Parent/Guardian) **Date**

A PHOTOCOPY OF BOTH SIDES OF MAJOR MEDICAL INSURANCE ID CARD MUST BE ATTACHED.

EXHIBIT J-j

CHILD CARE AGREEMENT

Parish/School/Entity
Child's name_____Birth date _____

Parent's Name_____Phone _____

Name of Physician_____Phone _____
Name to contact
in case of emergency_____Phone _____
Name of person authorized
to pick up child_____Phone _____

1. Does child have any medical condition necessitating dietary supplements or restrictions, medication or avoidance of allergies? Yes_____ No _____

   If yes, please specify:

   _____

   _____

2. Known allergies

   _____

3. Are there any restrictions on normal physical activities? Yes_____ No _____

   If yes, please specify:

   _____

   _____

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1. A child who appears ill upon arrival shall not be admitted.

2. At the time of registration, the parents should authorize the child's physician to accept all calls from the child care director for any emergency medical care.

I hereby authorize
_____ *to take my child to above named physician or facility for medical treatment in the event an emergency in which neither parent can be reached. If the above-named physician cannot respond, I authorize any licensed physician or medical center to treat my child.*
*Signature*_____*Date* _____

NOTE: A PHOTOCOPY OF BOTH SIDES OF HEALTH INSURANCE ID CARD MUST BE PROVIDED.