Diocese of Dallas Medical Release and Liability Waiver Form

____

Participant's Name: ________________________________ **Sex: (circle one)** M F **Birth Date:** _____ _ ____ **Age** ______

Parent/Guardian Name: ____

Home Address: ____

City: ______________________________ **State:** ____________________ **Zip:** ____________________

Home Phone: ( ) ______________________________ **Business Phone:** ( ) ______________________________

Parish Name & City: ______________________________ **Graduation year:** 03 04 05 06 07 ADULT

E-mail: ____

ADULTS ONLY - This box - ADULTS ONLY

Medical Release/Information

I agree on behalf of myself, my heirs, successors, and assign to hold harmless the Diocese of Dallas, the youth ministry program, their officers, directors, and agents from any liability for illness, injury or death arising from or in connection with my attending the ______________________ ______________________________. I understand that this is an event sponsored by the Diocesan youth ministry office and that it is presented by and through the Dioceses of Dallas.

In the event any legal action is taken by either party against the other party to enforce any of the terms and conditions of this agreement, it is agreed that the unsuccessful party to such action shall pay to the prevailing party therein all court costs, reasonable attorneys fees and expenses incurred by the prevailing party.

In the event that I should require medical treatment and I am not able to communicate my desires to attending physicians or other medical personnel, I give permission for the necessary emergency treatment to be administered. Please advise the doctors that I have the following allergies:

____.

In case of an emergency and for permission for treatment beyond emergency procedures, please contact:

Name: ______________________________ **Relationship to me:** ______________________________

Day Time Phone Numbers: ______________________________ **Night Time Phone Number:** ______________________________

Insurance Carrier: ____

Insurance Policy Number: ______________________________ **Insurance ID Number:** ______________________________

______________________________ ______________________________

Signature ***Date***

YOUTH The rest of the form is for: YOUTH

Parent/Guardian/Conservator Permission and Liability Waiver

I, ______________________________ grant my permission for my son/daughter, ______________________________

Parent/Guardian/Conservator signature *Participant's Name*

to participate in the ______________________________. I understand that this is an event sponsored by the Diocesan youth ministry office and that it is presented by and through the Diocese of Dallas.

I understand that as parent/legal guardian, I remain legally responsible for any personal actions taken by my son/daughter named above.

I agree on behalf of myself, my son/daughter named herein, our heirs, successors, and assigns to hold harmless, the Diocese of Dallas and its employees and/or volunteers from any and all claims for illness, injury, death and the cost of medical treatment therewith, arising from or in any way connected with my son's/daughter's attending the ____________________ during the dates named above.

In the event any legal action is taken by either party against the other party to enforce any of the terms and conditions of this agreement, it is agreed that the unsuccessful party to such action shall pay to the prevailing party therein all reasonable court costs, reasonable attorneys' fees and expenses incurred by the prevailing party.

______________________________ ______________________________

Parent/Guardian/Conservator signature ***Date***

If you are unable to reach me, please contact: ______________________________ Relationship to my child: ______________________________

Home Phone: ( ) ______________________________ Business Phone: ( ) ______________________________

Please fill out the information below OR attach a photocopy of your (child's) insurance card front and back.

Insurance Carrier:____

Policy Number: ___________________________________ Insurance ID Number: ___________________________

To the best of my knowledge, my child ____, is in good health, and I assume all responsibility for the health of my child. In the event of a medical emergency, I give permission to transport my child/for my child to be transported to a hospital for emergency medical or surgical treatment. I wish to be advised prior to any further treatment by the hospital or doctor.

____ ______________________________________

Parent/Guardian/Conservator signature Date

Sign only those statements in section 1 - 4 which are true and in accordance with your wishes.

Medications:

1. My child takes no medication and will bring no medication with him/her.

____ ______________________________________

Parent/Guardian/Conservator signature Date

2. My child takes medication/s and will self-medicate. My child will bring all such medications necessary, and such medications will be clearly labeled. I understand that my child will be required to turn all medication(s) over to a supervising adult designated to keep medication(s). I further understand that it will be my child's responsibility to present himself/herself at a location designated for returning medication(s) to my child at the frequencies/times listed below. I understand that the adult to whom my child surrenders the medication has no medical training and this adult will not measure dosages. My child will return the medication(s) to the adult after he/she self -medicates. At the conclusion of the event it will be my child's responsibility to pick up remaining medication(s), if any, at the self medication designated location. Names of medications and exact dosage and frequencies/times are as listed below:

____

____ ______________________________________

Parent/Guardian/Conservator signature Date

3. My child takes medication but is unable to self-medicate. The child's parent/guardian will provide and dispense any and all needed medications.

____ ______________________________________

Parent/Guardian/Conservator signature Date

4 a. No 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.

____ ______________________________________

Parent/Guardian/Conservator signature Date

4 b. I grant permission for the following non-prescription medication to be given to my child (EXCLUDING MEDICATIONS NAMED BELOW THAT MAY CAUSE ALLERGIC REACTION).

Non-aspirin pain reliever Yes_____ No_______ # of tablets per dosage______. Throat Lozenge Yes_____ No_____ Antacid Yes______ No______

Decongestant Yes_______ No______ # of tablets per dosage______. Antihistamine Yes_______ No______ #of tablets per dosage________.

Specific Medical Information for (circle one) Self or Child

____

Allergic reactions (medications, foods, plants, insects, etc.)

____

Immunizations: date of last tetanus/diphtheria immunization

____

Medications child currently takes

____

Any physical limitations

____

Is child subject to chronic homesickness, emotional reactions to new situations, sleepwalking, bedwetting, fainting?

____

Has your child recently been exposed to contagious disease or condition such as mumps, measles, chicken pox, etc.? If so, date and disease or condition.

____

You should also be aware of these special medical conditions of my child. *Please attach a clear description to this form*

Signature of Parent/Guardian/Conservator:____