Notary signature & seal required for all out of state activities.

Catholic Diocese of El Paso and/or the Parish of ________________________
Parent/Guardian/Conservator Permission, Liability Waiver and Medical Information

Youth Participant's Name:________________________ DOB:__________ **Male** ☐ **Female** ☐

Parent/Guardian/ Conservator's Name:________________________

Home Address:________________________ City__________ Zip:__________

Cell Phone: (_____)__________________ **Home Phone:** (_____)__________________

Release/Indemnification Information

I, ________________________ grant my permission for ________________________
Parent/Guardian/Conservator Name *Participant's Name*

to participate in the below described parish event. This activity will take place under the guidance and direction of parish employees and/or volunteers from the above named parish. The following is a brief description of the activity:

Description of event: ________________________
Date of event: ________________________
Destination of event: ________________________
____
Mode of transportation to and from event: ________________________

☐ *Transportation to/from event is the responsibility of the participant*

Individual(s) in charge: ________________ and ________________
Estimated time of departure and return: ________________________

During this event, I give permission for either of the adults named above in charge of the event to consent to emergency medical or surgical treatment for ________________________ *(Name of minor).*

I understand that as parent/guardian/conservator, I remain legally responsible for any personal actions taken by the participant named above.

I agree on behalf of myself, my son/daughter/participant named herein, our/his/her heirs, successors, and assigns to hold harmless, the Diocese of El Paso, Bishop and his successors, employees, agents, volunteers, the parish, it's employees and volunteers from any and all claims (unless due in part by gross negligence of the diocese and/or parish) for illness, injury, death and the cost of medical treatment therewith, arising from or in any way connected with my son/daughter/participant's attending the various programs and activities 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** __________

Emergency Contact Information

Emergency Contact Name:________________________ **Cell Phone**(_____)________________________

Relationship to the son/daughter/participant:________________________

Cell Phone: (_____)__________________ Texting: Yes ☐ No ☐

Home Phone:(_____)__________________ **Business Phone:**(_____)__________________

Medical Information

Is the participant insured? Yes ☐ No ☐ If yes, please fill out the information below *FROM THE PARTICIPANTS* Insurance Card:

Name of Policy Holder (whose name is the policy in)____

Insurance Carrier / Name of Insurance Company: ____

Policy number ____________________ **Insurance ID Number:**______________________________

Claim Address/Zip ____

Customer Service Phone Number: ____

Promotional Release

I consent to the use of any videotapes, photographs, slides, audiotapes, or any other visual or audio reproduction (in perpetuity unless otherwise revoked by me in writing and delivered by certified mail, return requested, to: Centro San Juan Diego, 901 W. Main Dr., El Paso, TX 79902 ATTN: Director, Office of Religious Formation) in which my son/daughter may appear by the Diocese of El Paso. I understand that these materials, including websites and social media sites, are used for promotion of the religious formation of the Diocese of El Paso which may include recruitment and fundraising efforts.

→ *Parent/Guardian/Conservator Signature* ____________________________________ **Date** ________________

Social Media Release

The Diocese of El Paso utilizes today's technology in a positive way to reach out to the youth of the diocese, including Facebook, email, and other social media. We may remove any content deemed inappropriate. All communications with any youth through social media programs by anyone representing the parish/diocese may be made available to a parent upon request. The diocese cannot guarantee that photos, videos, or other communications of your son/daughter from diocesan and /or parish events will not be uploaded to a social media site.

→ Parent/Guardian/Conservator Signature __________________________________ Date __________________

Prescription Medications: Check Box 1, 2, or 3 which is true for your child – DO NOT CHECK ALL BOXES

☐ **1.** This child takes no medication and will bring no medication with him/her.

☐ **2.** My son/daughter takes medication/s and will self-medicate. My son/daughter will bring all such medications necessary, and such medications will be clearly labeled. I understand that the 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 this child's responsibility to present himself/herself at a location designated for returning medication(s) to my son/daughter at the frequencies/times listed below. I understand that the adult to whom he/she surrenders the medication has no medical training and this adult will not measure dosages. My son/daughter will return the medication(s) to the adult after he/she self-medicates. At the conclusion of the event it will be my son/daughters 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: (you may attach a sheet to this form if you need more space just make sure to sign and date it as well).

____

____

☐ **3.** My son/daughter takes medication but is unable to self-medicate. I, parent/guardian/conservator will provide and dispense any and all needed medications.

NON-PRESCRIPTON MEDICATIONS: Check box A or B. Do NOT Check both boxes!

☐ **A. No medication of any type** whether prescription or non-prescription may be administered to this child unless the situation is life-threatening and emergency treatment is required.

☐ **B. I grant permission** for the following non-prescription medication to be given to this child (EXCLUDING MEDICATION LISTED BELOW THAT CAUSES ALLERGIC REACTION).

Non-aspirin pain reliever	Yes _____	No _____	# of tablets per dosage _________.
Decongestant	Yes _____	No _____	# of tablets per dosage _________ .
Antihistamine	Yes _____	No _____	# of tablets per dosage _________.
Throat Lozenge	Yes______	No______	
Antacid	Yes______	No______	

Specific Medical Information

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

____
Other Medications child currently takes

____
Any physical limitations

____
Has 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 this child. *Please attach a clear description to this form*

TO THE BEST OF MY ABILITY, EVERTHING I HAVE STATED HERE IS TRUE AND ACCURATELY REFLECT MY WISHES.

→ **Signature of Parent/Guardian/Conservator:**________________________________DATE ______________________

Witnessed by me,____________________________________ this _____ day of ______________, ________.
(year)

Notary's Signature:____ **Notary's Seal:**
(Required for all out of state activities)

(NOTARY SIGNATURE & SEAL REQUIRED FOR ALL OUT OF STATE ACTIVITIES)