Event:

Date:

Name Age Sex

Address City State Zip Phone

School Grade Birthday Parish

REGISTRATIONS MUST BE IN 7 DAYS PRIOR TO THE DATE OF THE WEEKEND

PERMISSION

I/we, the parents or guardians of the above mentioned child, for myself/ourselves and for my/our child, give
permission for my/our child to participate in the above mentioned Program on the above written dates.

MEDICAL AUTHORIZATION

In the event of any injury or illness to my/our child during his/her participation in this program, I/we hereby
give my/our permission for the necessary medical treatment to be given to my/our child. I/we agree that in case of injury to my/our child, I/we will apply my/our hospitalization and/or accident
insurance toward payment of the expenses incurred and will not look to the Department for Youth and Young
Adult Ministry, Gateway Clipper Fleet, the Catholic Institute or the Roman Catholic Diocese of Pittsburgh for
the payment of any medical costs or injury related costs.

Parent/Guardian Signature Parent/Guardian Signature

Insurance Company Policy Number

Name and Phone Number of Person if Parent/guardian is not available

CONSENT TO TREAT

I/We the undersigned parent(s)/guardian of _____, a minor, do hereby authorize treatment of my/our child by a licensed medical physician in case of any accident or illness that may so arise, or any hospitalization necessary.

_____ _____

Father/Legal Guardian Mother/Legal Guardian

Date: _____ This consent form will remain effective until _____

MEDICAL MATTERS: I hereby warrant that 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 those in accordance with your wishes...

1) Medications: My child is taking medication at present. My child will bring all such medications necessary, and such medications will be well labeled. My child will administer his/her own medication.

_____

Signature: _____ Date: _____

2) I hereby grant permission for nonprescription medication (such as Tylenol©, throat lozenges, cough syrup) to be given to my child, if deemed advisable.

Signature: _____ Date: _____

3) No medicating of any type whether prescription or nonprescription may be administered to my child unless the situation is life-threatening and emergency treatment is required.

Signature: _____ Date: _____

Any known allergies?: _____

Any physical limitations?: _____

Any medically prescribed dietary needs?: _____

Are you a vegetarian? ☐ YES ☐ NO

Is child subject to chronic homesickness, emotional reactions to new situations, sleepwalking, fainting? ☐ YES ☐ NO

If yes explain: _____