

St. Joseph Catholic Church Youth Ministry
Parental/Guardian Consent, Liability Waiver and Medical Consent
 1115 College Avenue, Conway, AR 72032 (501) 327-6568

Event: Girls Night Out Night to be held at the Round Mt Coffee, Conway

Date/Time & Details: Monday, Sept 30th 6:30pm

Ending Date/Time (est): Monday, Sept 30th, 7:30pm

Cost to participate: FREE **What to bring with you:** \$ for food (if you so choose)

Participant's Name: _____ **Date of Birth:** _____

Youth Cell Phone Number: (____) _____ **Youth Email Address:** _____

Parish: _____ **Grade** _____ **Age** _____ **Sex: M / F**

Parent/Guardian's Name: _____ **Email Address:** _____

Home/Cell Phone (Easiest number to reach you at) (____) _____

Would you like to chaperone? Yes No You will be contacted later.

PARTICIPANT CODE OF CONDUCT

The following are a few rules all participants are expected to follow while participating in this event:

- Treat all other persons with respect and not cause any intentional harm (physically, emotionally, or spiritually) to any person in any way.
- Respect the property of others, including all program facilities and property.
- Follow all appropriate instructions of all personnel aiding in this event, including, but not limited to, chaperones, support staff, transportation personnel and administration.
- Be on time for all check-in and departure times.
- Not have in my possession or use tobacco, alcohol or any controlled illegal substance.

I agree that if any of these terms are violated, Youth Ministry staff can send the participant home at the participant/guardian's expense.

I, _____ agree to this Code of Conduct. _____
 (Signature Name of Participant) (Date)

CONSENT & LIABILITY WAIVER

**Important! To be filled out by the Parent/Guardian for youth under 18 years of age.
 If participant is 18 years of age or older, consent must be signed by the participant.**

I (name of parent/guardian) _____, grant permission for my child, (participant's name) _____, to participate in the above listed event.

I agree on behalf of myself, my child's other parent if known, or living (name of parent) _____, my child named herein, or our heirs, successors, and assigns, to hold harmless and defend the Diocese of Little Rock, St. Joseph Catholic Church (its pastor, youth minister, other agents, etc.) or any representatives associated with the scheduled activity unless the parties involved were careless or negligent.

I give my son/daughter permission to be a passenger in a protocolled Adult Chaperone's car or ride a bus (as arranged by the St. Joseph Youth Ministry Department), for the purpose of going to and from the event listed at the top of this form. I understand all passengers in a private vehicle must wear seat belts, by my signature, I agree to hold harmless of neglect any adult chaperone, any staff member, the school, parish, or diocese, in case of an accident occurs while on this trip.

I give permission for my son/daughter, _____, to be photographed and to publish the photo in local, diocesan and parish media, both printed and electronic. I also give the Youth Ministry Department permission to contact my son/daughter through phone or electronic media regarding this event.

Signature (Parent/Guardian)

Date

Please complete both sides of this permission form

Signature (Participant 18 years of age or older must sign own consent)

Date

MEDICAL CONSENT

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, sign only those in accordance to your wishes:

Emergency Medical Treatment

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 any 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. (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

Allergic reactions to the following (foods, dyes, latex, etc.) _____

Has had 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 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)

NO NEED TO FILL OUT IF YOU HAVE COMPLETED THIS FOR PREVIOUS YOUTH EVENTS AND NOTHING HAS CHANGED!!

Insurance Carrier: _____

Name of Insured: _____

Insurance ID Number: _____ Insurance Policy Number: _____

Father's Name: _____ Birth Date: _____

Place of Employment: _____

Mother's Name: _____ Birth Date: _____

Place of Employment: _____

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 child 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).

Signature (Parent/Guardian)

Date

Signature (Participant 18 years of age or older must sign own consent)

Date

Please complete both sides of this permission form