"Rolling River Rampage" Registration

Family Name ________________ **Phone #** _________ **Email**_________________________

Parent or Guardian Name: ____

Address: ____

Home and Cell #'s ____

Alternative Pick Up Name/Phone #: ____

Are you able to volunteer: Yes No

If so what Day(s): _______________________________

Adult help is needed to make this week successful; even if you can only do a day every little bit helps.

— —

Child ____

Gr. (fall 2018)______ T-Shirt Size: XS S M L

Allergies/Medical Condition ____

— —

Child ____

Gr. (fall 2018)______ T-Shirt Size: XS S M L

Allergies/Medical Condition ____

— —

Child ____

Gr. (fall 2018)______ T-Shirt Size: XS S M L

Allergies/Medical Condition ____

— —

Child ____

Gr. (fall 2018)______ T-Shirt Size: XS S M L

Allergies/Medical Condition ____

Parent Signature ______________________________ **(reverse side for consent to treat)**

PERMISSION 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

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?: _________________________

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

If yes explain: ____

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, St. Winifred Parish, 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