PARISH FAMILY FORMATION - Bishop Garrigan Families
ANNUAL PARENT/GUARDIAN CONSENT FORM AND LIABILITY WAIVER

Family Name__________________________________ Parent(s) First Name(s) ____Parish _______________________

Address _________________________________ City/State/Zip ______________________________________ Email ____

Phones: home__________________ primary cell ______________________Mom/Dad*(circle)* Secondary cell_______________________ Mom/Dad*(circle)*

work ______________________________Mom/Dad *(circle)* work _______________________________Mom/Dad *(circle)*

Family FormationGrades K-7				**Sacraments Received**			**Special Instructions**
Childs Name	Grade	Gender	DOB	Baptism	1st Recon	1st Comm	
Family Formation Grade 2							

* Complete both sides of registration
* Under Sacraments received place a a on each one your child(ren) have received.
* Submit this form, along with your paymentno later than Aug 15 by:
  - dropping in the collection by Aug 15
  - bringing to the parish office
  - mail to: St. Cecelia Catholic Church
    715 E North
    Algona, IA 50511

FEES- Parish Family Formation K-7

$25.00 per Bishop Garrigan Family $_________

Total Due $___________

I give permission for my child's(ren) names and pictures to be used in the newspaper, on a website, Facebook or on church rectory, school bulletin boards. _______________*(initials)*

(OVER)

EMERGENCY CONTACT INFORMATION (<u>OTHER THAN PARENTS OR GUARDIANS</u>)

Name ____ Relationship _________________________________ Phone__________________________________

CONSENT FORM AND LIABILITY WAIVER

Family Doctor: ____ Phone Number: ______________________________________

PLEASE READ CAREFULLY:

I/We ______________________________________, the undersigned parent(s) or guardian(s) agree to the following. I grant permission for my child(ren) ____ to participate in parish youth ministry events that require transportation to a location away from the Parish site. Activities will take place under the guidance and direction of parish employees and/or volunteers from the Southern Kossuth County Cluster. I understand that a brief permission slip will be required for each event my child participates in during the calendar year. The brief permission slip will include (1) type of event (2) destination of event (3) individual in charge (4) estimated time of departure and return (5) mode of transportation to and from event (6) special characteristics of, or need for the event (7) line for the parent/guardian signature. As parent and/or legal guardian, I/we remain legally responsible for any personal actions taken by the above named minor(s) "participant(s)". I agree on behalf of myself, my child(ren) name herein, my spouse, and the Diocese of Sioux City, chaperones, and representatvies associated with the event, (referred collectively as "them"), that: We release and forever discharge them from any and all claims and causes of action that we may have against them, arising in connection with the activities of the participating child(ren) while attending an event or in connection with any illness or injury or cost of medical treatment therewith, in so much as they have made reasonable efforts to maintain the safety of my child(ren) while in their care and my child(ren) has/have complied with all rules and instructions of the program.

Parent/Legal Guardian's Signature ____ Date ______________________

MEDICAL MATTERS

Of the following statements pertaining to medical matters, please initial only those that are applicable.

EMERGENCY MEDICAL TREATMENT: In the even of an 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. ___________

OTHER MEDICAL TREATMENT: I HEREBY GRANT PERMISSION FOR NON-PRESCRIPTION MEDICATION (such as Tylenol, throat lozenges, cough syrup) be given to my child(ren), if deemed appropriate. ___________

NO MEDICATION OF ANY TYPE, whether prescription or non-prescription, may be administered to my child(ren) unless the situation is life-threatening and emergency treatment is required. ___________

SPECIAL MEDICAL INFORMATION

Please list any information of ALL children in the given spaces. Please indicate which child you are referring to. Allergic Reactions (to medications, food, plants, insects, etc.) or medically prescribed diet or any special restrictions, physical limitations or medical conditions:

If your child must take medication during an event endorsed by the Southern Kossuth County Cluster, please send it with the child in a baggie with clear and concise directions as to how to administer the medicine.

I hereby warrant that to the best of my knowledge, my child(ren) is/are in good health and I assume all responsibility for the health of my child(ren). I have reviewed and completely and accurately completed this medical information. It will be assumed in the event it comes to the attention of the Southern Kossuth County Cluster director and/or volunteer that my child(ren) become ill or injured I will be called. ____

Signature/Date