ST. MATTHEW CYO

MEMBERSHIP PROFILE

DUES $25.00

TO: SMA CYO

July 1, 2020 to June 30, 2021

NAME_____

ADDRESS_____

City, State & Zip_____

HOME #_____Youth CELL# _____

GRADE_____AGE_____DATE of BIRTH_____

CYO member E-MAIL ADDRESS_____

E-MAIL ADDRESS #2 _____

PRESENT SCHOOL ATTENDING_____

RESIDING CHURCH PARISH_____

SCHOOL INVOLEMENTS: _____

_____

HOBBIES:_____

MOTHER'S NAME_____CELL# _____

Mother's Occupation_____

EMAIL:_____

FATHER'S NAME_____CELL # _____

Father's Occupation_____

EMAIL:_____

_____ _____

SIGNATURE OF MEMBER DATE

PLEASE DO NOT WRITE BELOW THIS

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DATE RECEIVED_____ CASH CHECK#_____ ACCOUNT

St. Matthew the Apostle CYO
ARCHDIOCESE OF NEW ORLEANS
MEDICAL INFORMATION AND CONSENT FORM

GENERAL INSTRUCTIONS TO PARENTS/GUARDIANS:

1. Please take care in filling out this form. It provides crucial information for caregivers in the event of illness or medical emergency. Accuracy and thoroughness are encouraged.
2. **Sections I, II and V are mandatory**. Sections III and IV provide you with treatment options in non-emergency situations.

Participant's name: _____

Birth date: _____ Sex: _____

Parent/Guardian's name _____

Home address: _____
(Street) (City/State) (Zip)

Home phone: _____ Parent/Guardian cell phone: _____

Business phone: _____ Other: _____

SECTION I. MEDICAL MATTERS

As the parent/legal guardian of the above named child, who is currently associated with St. Matthew the Apostle Parish. I hereby authorize Fr. Lee Poche or his/her assistants to carry out the wishes I have named (herein) in areas of emergency medical treatment and other cases of illness. This authorization inclusively extends from July 1, 2020 through June 30, 2021. 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.

Signature: _____ Today's Date: _____

SECTION II. EMERGENCY MEDICAL TREATMENT

In the event 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. In the event of an emergency, if you are unable to reach me at the numbers listed herein, contact:

Name & relationship: _____

Home Phone: _____ Cell Phone#: _____

Family doctor: _____ Phone: _____

Family Health Plan Carrier: _____ Policy #: _____

Signature: _____ Date: _____

PLEASE ATTACH MEDICAL INSURANCE CARD

SECTION III: OTHER MEDICAL TREATMENT

In the event it comes to the attention of the parish, its officers, directors and agents, chaperones, or representatives associated with the activity that my child becomes ill with symptoms such as headache, vomiting, sore throat, fever, diarrhea, I want to be called collect (with phone charges reversed to myself).

Signature _____ Date: _____

SECTION IV: MEDICATIONS

(SIGN ONLY THOSE OPTIONS THAT ARE APPLICABLE)

- My child is taking medication at present. My child will bring all such medications necessary, and such medications will be well-labeled. Names of medications and concise directions for seeing that the child takes such medications, including dosage and frequency of dosage, are as follows: _____

  _____

  Signature: _____ Date: _____

- I hereby grant permission for non-prescription medication (such as aspirin, throat lozenges, cough syrup) to be given to my child, if deemed appropriate.

  Signature: _____ Date: _____

- NO medication of any type, whether prescription or non-prescription, may be administered to my child unless the situation is life-threatening and emergency treatment is required.

  Signature: _____ Date: _____

SECTION V: MEDICAL INFORMATION

The parish will take reasonable care to see that the following information will be held in confidence:

*Allergic reactions (medications, foods, plants, insects, etc.): _____

***Immunizations:** **Date of last tetanus**/diphtheria immunization: _____ **(YEAR)**

*Does child have a medically prescribed diet? _____

*Any physical limitations? _____

*Is child subject to chronic homesickness, emotional reactions to new situations, sleepwalking, bed-wetting, fainting?

_____

*Has child recently been exposed to contagious disease or conditions, such as mumps, measles, chickenpox, etc? _

_____

If so, date and disease or condition: _____

*You should be aware of these special medical conditions of my child: _

_____

_____

St. Matthew the Apostle CYO Release Form

I,_____the undersigned parent/guardian

of_____a dues paid member of St. Matthew the Apostle Catholic Youth Organization (SMA CYO), hereby grant permission to SMA CYO and/or the Archdiocese of New Orleans to publish and/or print my/our child's name and/or likeness on the SMA CYO website, Facebook, on the internet and/or world wide web.

I hereby further release, indemnify and hold harmless SMA CYO, the Roman Catholic Church of the Archdiocese of New Orleans, their directors, officers, agents, pastor, employees and insurers from any and all claims and/or damages on behalf of myself/ourselves and/or our child arising from the publication of my/our child's names, photograph, or likeness on videotape and/or film on SMA CYO web site, Facebook, on the internet or the world wide web.

This agreement shall remain in force and effect at all times during my child's membership at St. Matthew the Apostle Catholic Youth Organization.

_____ _____

Member's Signature Date

_____ _____

Parent/Guardian Signature Date