

MEDIA AND CIRCLE OF GRACE FAMILY CONSENT FORM

St. Basil / St. Veronica Religious Education Program engages in various correspondence and publicity items with families, parishioners and other members of the community regarding various aspects of this program. Parents are given the option of authorizing the use of their children's photos with or without names for those purposes.

As part of the Safe Environments initiative to keep our children safe, the Archdiocese of Detroit has mandated a program for children called "Circle of Grace". Every Religious Education Program is to present one lesson each year on this topic of personal safety. The lessons are grade appropriate and present basic concepts such as:

- *Children are created by God and live in the love of the Father, Son and Holy Spirit.*
- *God gives us a circle of grace, which is the love and goodness of God which surrounds each of us.*
- *Children have physical, spiritual, emotional and sexual boundaries.*
- *How to recognize when these boundaries are violated.*
- *How to take action if a boundary is threatened or violated.*

Please note that this is NOT sex ed. The information is for the personal safety of children in the event that they are confronted by someone who violates their boundaries of safety.

(1) I give permission for my child to be photographed or videotaped for educational and community relations not-for-profit use, such as newsletter articles, parish bulletin articles, community newspapers, etc.

(2) I give permission for my child's name to accompany my child's photo or video published for community relations/ PR purposes.

(3) My child may participate in the Circle of Grace presentation

Child's Name	(1) Authorization to photograph my child		(2) Authorization to use my child's name		(3) Circle of Grace participation consent	
	Yes	No	Yes	No	Yes	No
	Yes	No	Yes	No	Yes	No
	Yes	No	Yes	No	Yes	No
	Yes	No	Yes	No	Yes	No

Signature: _____ Date: _____
(Signature of parent or guardian)

Name: _____
(Printed name of parent or guardian)

Please complete the information below and return to the Director of Religious Education at the time of registration.

Parents may cancel this authorization at any time by providing written notice to the Religious Education Office.

MEDICAL TREATMENT RELEASE FORM

To Whom It May Concern:

As parent/guardian, I do hereby authorize the treatment of a qualified and licensed physician of any condition which, in the opinion of the physician, is deemed necessary and appropriate. This authority is granted only after a reasonable effort has been made to reach me.

Name of Minor: _____ **Relationship to you** _____

Reason for which release is intended: _____ **Address of Minor:** _____

City: _____ **Emergency Phone (s) :** _____

Emergency Contact Person: _____ **Family Physician:** _____

Phone: _____ **Physician Address:** _____ **City:** _____

List allergies, medication, or other pertinent comments: _____

Name of Minor: _____ **Relationship to you** _____

Reason for which release is intended: _____ **Address of Minor:** _____

City: _____ **Emergency Phone (s) :** _____

Emergency Contact Person: _____ **Family Physician:** _____

Phone: _____ **Physician Address:** _____ **City:** _____

List allergies, medication, or other pertinent comments: _____

Name of Minor: _____ **Relationship to you** _____

Reason for which release is intended: _____ **Address of Minor:** _____

City: _____ **Emergency Phone (s) :** _____

Emergency Contact Person: _____ **Family Physician:** _____

Phone: _____ **Physician Address:** _____ **City:** _____

List allergies, medication, or other pertinent comments: _____

Family Health Insurance Data (If you do not wish to share, we respect your right to privacy):

Company: _____ **Policy:** _____ **Group:** _____

I further authorize the person who presents the minor to sign the Acknowledgment of Receipt of Notice Privacy Rights that may be presented by the physician or health care facility. This authorization is completed and signed of my own free will with the sole purpose of authorizing medical treatment deemed necessary and appropriate by the treating physician.

Date: _____ **Signed:** _____

(Parent or Guardian)