

**Saint Bartholomew Youth Group 2009-2010**  
**600 Columbia Drive • San Mateo, CA 94402**  
**650.347.0701 ext. 11 • www.barts.org**

**Permission slip, Medical Release and Waiver Form Relating to Minors**  
**One copy will be kept on file in Initiation Coordinator's office.**  
**One copy will be kept with the Catechists in case of emergency during class.**

I (we), the undersigned parent(s) or guardian(s) of the participant listed below, give my (our) permission for him/her to participate in any and all activities sponsored and/or organized by St. Bartholomew's Church during the 2009/2010 year. I (we) hereby direct my (our) child to conform with the directions of parish personnel responsible for the activity.

I (we) hereby authorize the Initiation Coordinator, Youth Minister, and/or their associates who provide transportation or supervisory support, as my (our) agents. This authorization empowers the agent(s) to consent to any x-ray examination, anesthetic, medical, surgical, or dental diagnosis, treatment, or hospital care which is deemed advisable by and is rendered under the supervision of any licensed physician, surgeon, or dentist. It is understood that the aforesaid agent(s) will make every effort to contact us in case of emergency prior to authorizing such treatment. This authorization is given pursuant to the provisions of section 25.8 of the Civil Code of California.

I (we) are not aware of any medical condition of my (our) child which would render it unsafe for my (our) child to participate in any of the activities my (our) child attends.

It is understood that I (we), as permitted by law, waive, release and discharge any and all claims for damages for death, personal injury, loss or property damage which I (we) may have against the Roman Catholic Archbishop of San Francisco, A Corporate Sole, his designees and associates and St. Bartholomew Church as a result of his/her participation in these events, including transportation to and from the activity, whether or not caused by the negligence (active or passive) of St. Bartholomew Youth Ministry, St. Bartholomew's Faith Formation Program, the Archdiocesan Youth activities program or any of its agents or employees. Recourse for the payment or any resulting hospital, medical, dental or related costs will first be had against any accident, hospital or medical insurance, or any other benefit plan of mine or my spouse. **(PLEASE USE INK OR BALLPOINT PEN)**

**STUDENT'S NAME** \_\_\_\_\_ **BIRTHDATE** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Last First Middle Month Day Year

**ADDRESS** \_\_\_\_\_  
Address City Zip

**HOME PHONE** \_\_\_\_\_ **STUDENT'S CELL PHONE** \_\_\_\_\_

**STUDENT'S EMAIL** \_\_\_\_\_ **CHECKED:** [  ] Daily; [  ] Weekly; [  ] Less

***PARENT INFORMATION***

**Father's Name** \_\_\_\_\_ **Mother's Name** \_\_\_\_\_

**Home Phone** \_\_\_\_\_ **Home Phone** \_\_\_\_\_

**Occupation** \_\_\_\_\_ **Occupation** \_\_\_\_\_

**Work Phone** \_\_\_\_\_ **Work Phone** \_\_\_\_\_

**Cell Phone** \_\_\_\_\_ **Cell Phone** \_\_\_\_\_

**Email Address** \_\_\_\_\_ **Email Address** \_\_\_\_\_

**CHECKED:** [  ] Daily; [  ] Weekly; [  ] Less

**CHECKED:** [  ] Daily; [  ] Weekly; [  ] Less

**SCHOOL STUDENT ATTENDS** \_\_\_\_\_ **GRADE IN FALL 2009** \_\_\_\_\_

**PARENT SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_

### Medical Information

**Emergency Contact:** In case of illness, accident or major emergency list at least 3 adults other than parents who have permission to care for your child. Please notify each of them regarding this permission.

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Relationship to child: \_\_\_\_\_

Home phone: ( ) \_\_\_\_\_ Work phone: ( ) \_\_\_\_\_

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Relationship to child: \_\_\_\_\_

Home phone: ( ) \_\_\_\_\_ Work phone: ( ) \_\_\_\_\_

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Relationship to child: \_\_\_\_\_

Home phone: ( ) \_\_\_\_\_ Work phone: ( ) \_\_\_\_\_

EMERGENCY PHONE NUMBER OUTSIDE CALIFORNIA TO BE USED IN CASE OF DISASTER ( ) \_\_\_\_\_

**HEALTH HISTORY:** Does your child have or is your child subject to any of the below **FREQUENTLY?**

- |                        |                          |                            |
|------------------------|--------------------------|----------------------------|
| _____ Diabetes         | _____ Ear Infection      | _____ Asthma               |
| _____ Colds/congestion | _____ Headaches          | _____ Hay Fever            |
| _____ Food Allergy     | _____ Hepatitis          | _____ Insect Sting Allergy |
| _____ Medicine Allergy | _____ Poison Oak Allergy |                            |

How are any **YES** answers handled at home:

Name of any medication(s) your child takes on a regular basis:

Instructions for administering above medications(s):

LOCAL PHYSICIAN \_\_\_\_\_ PHONE \_\_\_\_\_

LOCAL DENTIST \_\_\_\_\_ PHONE \_\_\_\_\_

MEDICAL INSURANCE CARRIER: \_\_\_\_\_

MEDICAL INSURANCE CARD NUMBER: \_\_\_\_\_

**For office use only: Student released to:**

Name \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

Where will child be taken? \_\_\_\_\_