

Saint Bartholomew Youth Group 2006-2007
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 2006/2007 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 2006** _____

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? _____