

**NO STAPLES**  
**PLEASE**

**CHILD'S NAME** \_\_\_\_\_  
First Middle Last

**GRADE** \_\_\_\_\_  
Fall of 2007

**FAMILY NAME** \_\_\_\_\_  
please use print in ink

**Permission slip, Medical Release and  
Waiver Form Relating to Minors**

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 Parish during the 2007/2008 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 Youth Minister, Faith Formation Administrator, Sacramental Coordinator, 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 Parish 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 PRINT IN BLUE OR BLACK INK)**

CHILD'S NAME \_\_\_\_\_  
First Middle Last

ADDRESS: \_\_\_\_\_  
Street City Zip

SCHOOL: \_\_\_\_\_ GRADE: \_\_\_\_\_ AGE: \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_

Child living with: Both parents \_\_\_\_\_ Father \_\_\_\_\_ Mother \_\_\_\_\_ Guardian \_\_\_\_\_

FATHER: \_\_\_\_\_ MOTHER: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ ADDRESS: \_\_\_\_\_

HOME PHONE: (\_\_\_\_) \_\_\_\_\_ HOME PHONE: (\_\_\_\_) \_\_\_\_\_

WORK/CELL PHONE: (\_\_\_\_) \_\_\_\_\_ WORK/CELL PHONE: (\_\_\_\_) \_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_ EMAIL ADDRESS: \_\_\_\_\_

**PARENT/GUARDIAN SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**\*OTHER PARENT/GUARDIAN SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

\* while being sensitive to single parent situations and possible embarrassment to the children, signatures of both parents should be obtained when possible.

**(Please complete reverse side)**

**05/07/07**

### 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? \_\_\_\_\_

05/07/07