

CHILD'S NAME _____
First Middle Last

GRADE _____
Fall of 2011

FAMILY NAME _____
please use print in ink

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

I (we), the undersigned parent(s) or guardian(s) of the participant listed above, 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 2011/2012 year. I (we) hereby direct my (our) child to conform with the directions of parish personnel and volunteers responsible for the activity.

I (we) grant permission to St. Bartholomew's Parish personnel and volunteers to take photographs of the participant while engaged in any and all activities sponsored and/or organized by St. Bartholomew's Parish. I authorize the use of the same in print and/or electronically, without his/her name and for any lawful purpose, including such purposes as publicity, illustration, advertising, and Web content.

I (we) hereby authorize the Youth Minister, Faith Formation Administrator, Parish Catechetical Leader, 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)**

ADDRESS: _____
(if different than shown above) Street City Zip

SCHOOL: _____ GRADE: _____ AGE: _____ BIRTHDATE: _____

Child living with: Both parents _____ Father _____ Mother _____ Guardian _____

FATHER: _____ MOTHER: _____

ADDRESS: _____ ADDRESS: _____
(if different than above) (if different than above)

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)

06/28/11

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? _____