ST. PATRICK YOUTH MINISTRY PERMISSION/MEDICAL WAIVER

PERMISSION INFORMATION

NAME OF YOUTH___________________________________ I, ____

parent/guardian request that my child, named above, be allowed to participate in the activity

____ on(date) _______________________________sponsored by St. Patrick Catholic Church. The programmatic/education purpose of these activities will focus on one or more of the following components: Social, Service or Spiritual.

I further give my permission for my child to ride in any vehicle designated by the adult in whose care my child has been entrusted while participating in the above activities.

I give my permission to use my child(ren's) name, photograph and/or videotaped image in print/video on the St. Patrick Website, St. Patrick or YM Facebook Pages or St. Patrick's YM Instagram and Twitter ______Yes _____ No

I give my permission for the Youth Minister to TEXT my child(ren) regarding Youth Ministry events. ___ Yes ___ No

In consideration of permitting my child to attend and/or participate, I do hereby, for myself, and my child (children), waive and release any and all claims that I might have against St. Patrick Catholic Church, the Archdiocese of Louisville, the Director of Youth Ministry and any chaperones or designated drivers of a van, bus, car or vehicle, for any and all injuries or losses suffered by said child(ren) while engaged in the above activities.

In case of any medical emergency, I understand that every effort will be made to contact the parents or guardians of the child participating in the Youth Ministry Programming of the parish. In the event that I cannot be reached, I hereby give permission to the physician selected by the Youth Minister to hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery for my child, as named herein.

Signature of Parent/Guardian	**Date**

MEDICAL INFORMATION

Youth Name________________________________ Date of Birth__________________ Male_____Female_____

Current Grade__________ Youth Cell Phone_________________Youth E-Mail___________________________________

Parent/Guardian Name____

Address____Parent Email(s) _______________________________

Mom Cell #___________________Dad Cell# __________________ Home/Work_________________________________

Medical Info: Is your child in general good health and able to participate in normal activities?

Yes ___ No___ (Please submit a statement indicating limitations.) Please call or write if I should know anything else about child's history. **Food Allergies:** ____

Medicine Allergies:____**Other Allergies:** _______________________

Current Medications: ____

Please notify Youth Minister if your child has been exposed to any communicable disease during 3 weeks prior to an activity.

Doctor Information:

Family Physician or Clinic:_______________________________________Physician Phone #:__________________________

Insurance Information:

Insurance Company:______________________________________Policy #________________Group #_______________

Emergency Contacts

Name/Phone____

Name/Phone____

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Signature of Parent/Guardian	**Date**

Please sign in box

Please direct questions or return form to: Jonna O'Bryan, Director of Youth Ministry at 244-6083 ext 102 Office or (812) 449-6560 Cell or jobryan@stpatrick-lou.org