

# 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 \_\_\_\_\_

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.

<b>Signature of Parent/Guardian</b>	<b>By Checking this box I agree this is my electronic Signature</b>	<b>Date</b>
If sending electronically please type in Name and 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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<b>Signature of Parent/Guardian</b>	<b>By Checking this box I agree that this is my electronic Signature</b>	<b>Date</b>
If sending electronically please type in Name and Date:		

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](mailto:jobryan@stpatrick-lou.org)**