



PARENTAL/GUARDIAN CONSENT FORM & LIABILITY WAIVER

Office of Faith Formation
-Youth Ministry
P. O. Box 230
Wheeling, WV 26003

Participant's Name _____

Birth Date: _____ **Sex:** _____

Parent/Guardian's Name: _____

Home Address: _____

Home Phone: _____ **Business Phone:** _____

I, _____, grant permission for my child, _____
Parent or Guardian's Name Child's Name

to participate in this Office of Youth Ministry event. This activity will take place under the guidance and direction of volunteers from the Office of Youth Ministry. A brief description of the activity follows:

Type of Event: _____

Destination of Event: _____

Individual in Charge: _____

Estimated time of departure and return: _____

Mode of transportation to and from event: _____

As parent/and or legal guardian, I remain legally responsible for any personal actions taken by the above named minor (participant).

I agree on behalf of myself, my child named herein, or our heirs, successors, and assigns, to hold harmless and defend the Youth Ministry Office, its officers, directors and agents, and the Diocese of Wheeling-Charleston, chaperons, or representatives associated with the event, arising from or in connection with my child attending the event or in connection with any illness or injury or cost of medical treatment in connection therewith, and I agree to compensate the parish, its officers, directors, and agents, and the Dioceses of Wheeling-Charleston, chaperons, or representative associated with the event for reasonable attorney's fees and expenses arising in connection therewith.

Signature: _____ Date: _____

MEDICAL MATTERS: I hereby warrant that to the best of my knowledge, my child is in good health, and I assume all responsibility for the health of my child. (Of the following statements pertaining to medical matters, sign only those that are applicable.)

EMERGENCY MEDICAL TREATMENT: In the event of an emergency, I hereby give permission to transport my child to a hospital for emergency medical or surgical treatment. I wish to be advised prior to any further treatment by the hospital or doctor. In the event of an emergency, if you are unable to reach me at the above numbers, contact:

Name & Relationship: _____

Phone: _____ Family Doctor: _____ Phone: _____

Family Health Plan Carrier: _____ Policy#: _____

Signature: _____ Date: _____

Other Medical Treatment: In the event it comes to the attention of the Youth Ministry Office, its officers, directors and agents, and the Diocese of Wheeling-Charleston, chaperons, or representatives associated with the activity that my child becomes ill with symptoms such as headache, vomiting, sore throat, fever, diarrhea, I want to be called collect (with phone charges reversed to myself).

Signature: _____ Date: _____

No medication of any type, whether prescription or non-prescription, may be administered to my child unless the situation is life threatening and emergency treatment is required.

Signature: _____ Date: _____

I hereby grant permission to non-prescription medications such as (aspirin, throat lozenges, cough syrup) to be given to my child, if deemed appropriate.

Signature: _____ Date: _____

Specific Medical Information: The Youth Ministry Office will take reasonable care to see that the following information be held in confidence.

- Allergic reactions (medications, foods, plants, insects, etc.): _____
- Immunizations: Date of last tetanus/diphtheria immunization: _____
- Does child have a medically prescribed diet? _____
- Any physical limitations? _____
- Is child subject to chronic homesickness, emotional reactions to new situations, sleepwalking, bedwetting, fainting?

- Has child recently been exposed to contagious disease or conditions, such as mumps, measles, chickenpox, etc.? If so, date, disease or condition: _____
- You should be aware of these special medical conditions of my child: _____
