

# DIOCESE OF YAKIMA

## PARENTAL/GUARDIAN CONSENT FORM AND LIABILITY WAIVER

Participant's name \_\_\_\_\_

Birth date \_\_\_\_\_ Sex \_\_\_\_\_

Parent/Guardian's name \_\_\_\_\_

Home address \_\_\_\_\_

Home phone \_\_\_\_\_ Work phone \_\_\_\_\_

I, \_\_\_\_\_, grant permission for my child, \_\_\_\_\_,

Parent/Guardian name

Child's name

to participate in this parish/school/youth ministry event that requires transportation to a location away from the parish/school/youth ministry site. This activity will take place under the guidance and direction of employees and/or volunteers from \_\_\_\_\_ Vocations Office \_\_\_\_\_.

A brief description of the activity follows:

Type of event \_\_\_\_\_ Quo Vadis Days Camp \_\_\_\_\_

Destination of event \_\_\_\_\_ Cle Elum \_\_\_\_\_

Individual in charge \_\_\_\_\_ Rev. Felipe Pulido \_\_\_\_\_

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 \_\_\_\_\_, its officers, directors & agents,

Parish/school/youth group

and the \_\_\_\_\_, chaperons, or representatives associated with the

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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 \_\_\_\_\_,

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chaperons, or representatives 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.) I understand that my medical insurance is always primary.

**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. **Please be aware that your medical insurance is always primary.** 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 parish/school/youth group, its officers, directors, and agents, and the, \_\_\_\_\_ chaperons, or  
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representatives associated with the activity that my child becomes ill with symptoms such as a headache, vomiting, sore throat, fever, diarrhea, I want to be called collect (with phone charges reversed to myself).

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Medications:** My child is taking medication at present. My child will bring all such medications necessary, and such medications will be well labeled. Names of medications and concise directions for seeing that the child takes such medications, including dosage and frequency of dosage, are as follows: \_\_\_\_\_

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 for non-prescription medication (such as non-aspirin products, i.e. acetaminophen or ibuprofen, throat lozenges, cough syrup) to be given to my child, if deemed appropriate.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Specific Medical Information:** The parish/school/youth group will take reasonable care to see that the following information will 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 and disease or condition: \_\_\_\_\_

You should be aware of these special medical conditions of my child: \_\_\_\_\_