Saint Catherine of Siena Catholic Church

Permission Slip

Activity:

Location:

Date/Time:

Participant's Full Name: _____ **Gender**: **M/F**

Address: _____ Zip: _____

Parent Name(s): _____

Home Number: _____ Daytime number of Parent: _____

Emergency Contact (Other than parent): _____ Phone: _____

Any allergies or medical, physical, or dietary restrictions/requirements: _____

_____

Medications presently taking (and the condition the medication is treating): _____

_____

_____

Medical Insurance Company: _____

Policy ID Number: _____

(Second half of form on reverse of this page)

(First half of form on reverse of this page)

If your child may participate in this event, please complete, sign and return the following statement of consent and release of liability. As parent/guardian, you remain fully responsible for any liability, which may result from personal actions taken by your son/daughter. **If your youth brings or uses any drugs, alcohol, weapons, or tobacco products or engages in reckless or violent behavior, you will be expected to retrieve your son/daughter from the event/trip immediately.**

I hereby consent to the participation of my child, _____, in the event described above. I further consent to the conditions stated above regarding participation in this event, including the method of transportation.

I release the Diocese of Raleigh, St. Catherine of Siena and their agents and volunteers from any injuries, which may be incurred by my youth.

I give permission for my child, in case of emergency, to be taken to a physician or hospital by either an adult youth leader, diocesan or parish personnel. I understand that every effort will be made to contact me. *If I cannot be reached*, however, I hereby give permission to the physician selected by the adult in charge, to hospitalize and secure proper treatment, including surgery, for my son/daughter.

I hereby grant permission to any staff person to provide the following over-the-counter drugs to my son/daughter if requested by my son/daughter (please check all that apply (Note: category of medicine and an example are listed, although a different brand may be used.) Doses are not to exceed manufacturer's recommended dosages.

___ Ibuprofen (Advil)
___ Acetaminophen (Tylenol)
___ Antibiotic Ointment (Neosporin)
___ Antihistamine/Decongestant (Actifed/Sudafed/Benadryl)
___ Antacids (Rolaids/Tums)

Parents/guardians of participants are advised that photographs or videotape of participants may be used in publications, websites or other materials produced from time to time by the Youth Apostolate Office or the Diocese of Raleigh. Participants would not be identified unless specific written consent is given. Parents/guardians who do not wish their children to be photographed or filmed should so notify the Office in writing.

Parent/Guardian
Signature _____ Date _____