

# Diocese of Little Rock / Office of Catholic Youth Ministries

## PARENTAL/GUARDIAN MEDICAL CONSENT AND LIABILITY WAIVER

Participant's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Parent/Guardian's Name: \_\_\_\_\_ Home Phone(\_\_\_\_) \_\_\_\_\_

Alternate Phone Number: (\_\_\_\_) \_\_\_\_\_  Cell Phone  Pager  Work

Parish: \_\_\_\_\_ Grade \_\_\_\_\_ Age \_\_\_\_\_ Sex: M/F

### CONSENT & LIABILITY WAIVER

**Important! To be filled out by the Parent/Guardian for youth under 18 years of age.  
If participant is 18 years of age or older, consent must be signed by the individual.**

I (name of parent/guardian) \_\_\_\_\_, grant permission for my child, (participant's name) \_\_\_\_\_, to participate in (event) \_\_\_\_\_, to be held (date) \_\_\_\_\_, (time) \_\_\_\_\_ and (location) \_\_\_\_\_.

I agree on behalf of myself, my child's other parent if known, or living (name of parent) \_\_\_\_\_. My child named herein, or our heirs, successors, and assigns, to hold harmless and defend the Diocese of Little Rock, the sponsoring parish (its pastor, youth minister, other agents, etc.) or any representatives associated with the scheduled activity unless the parties involved were careless or negligent.

\_\_\_\_\_  
**Signature (Parent/Guardian)**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Signature**  
(Participant 18 years of age or older must sign own consent)

\_\_\_\_\_  
**Date**

## MEDICAL CONSENT

### Medical Matters

I hereby warrant 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 in accordance to your wishes:

### Emergency Medical Treatment

In the event of any 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 any emergency and you are unable to reach me, contact:

Name & Relationship \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Family Doctor: \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

### Medications

My child will bring all such medications, well labeled, that are necessary. Names of medications and concise directions for seeing that the child takes such medications, including dosage and frequency are as follows:

My child is taking the following medication at the present time:

Medication(s): \_\_\_\_\_ Dosage \_\_\_\_\_ Medication \_\_\_\_\_ Dosage \_\_\_\_\_ Medication \_\_\_\_\_ Dosage \_\_\_\_\_

Administer: \_\_\_\_\_

\_\_\_\_\_ I hereby **DO NOT GRANT PERMISSION** for medication of any type, whether prescription or nonprescription may be administered by my child unless the situation is life threatening and emergency treatment is required. (Please initial)

\_\_\_\_\_ I hereby **GRANT PERMISSION** for nonprescription medication (such as Tylenol, throat lozenges, cough syrup) to be given to my child, if deemed advisable. (Please initial)

### MEDICAL CONDITIONS INFORMATION

(Diocesan personnel will take reasonable care to see that the following information will be held in confidence)

My son/daughter has: \_\_\_\_\_

Has had an episode of the following or has been diagnosed  Seizures  Asthma  Diabetic

Allergic reactions to the following (foods, dyes, latex, etc.) \_\_\_\_\_

Has had medical surgery within the last six months?  Yes  No Still under Doctor's care? Yes  No

Has a medically prescribed diet? \_\_\_\_\_

The following physical limitations? \_\_\_\_\_

Immunizations current and up to date:  Yes  No Date of last tetanus/diphtheria immunization \_\_\_\_\_

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

### INSURANCE INFORMATION

(Please attach a copy of the Insurance Card, front and back, with this form)

Insurance Carrier: \_\_\_\_\_

Name of Insured: \_\_\_\_\_

Insurance ID Number: \_\_\_\_\_ Insurance Policy Number: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Place of Employment: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Place of Employment: \_\_\_\_\_

No, I do not carry medical insurance at this time.

In the event it comes to the attention of the chaperones associated with the activity that my child becomes ill with repeated symptoms such as headache, vomiting, sore throat, fever, diarrhea, I want to be called immediately. If this will be a long distance call, I want to be called collect (with phone charges reversed to myself).

\_\_\_\_\_  
**Signature (Parent/Guardian) Parent Guardian must sign for anyone under 18 years of age** **Date**

\_\_\_\_\_  
**Signature (Participant 18 years of age or older must sign own consent)** **Date**