

WITNESS LEADERSHIP RETREAT

St. Helen Youth Ministry

June 16, 2018 • St. Helen • 9am-6:15pm • Lunch Provided

\$5 Donations

PARENT/GUARDIAN CONSENT FORM & LIABILITY WAIVER

Participant's Name _____ Date of Birth _____

Home Address _____ City/Zip Code _____

Parent(s)/Guardian(s) _____

Cell Phone Number: (____) _____ Home Phone (____) _____

Parish: St. Helen Catholic Church School: _____

Grade (On Date Of Event): _____ Age (On Date Of Event): _____ Sex M / F

Parent's Email Address: _____

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 **St. Helen's Witness
Leadership Retreat that is taking place at St. Helen Catholic Church.**

I agree on behalf of myself, my child's other parent if known or living (name of other parent),
_____, my child named herein, or our heirs, successors, and assigns and defend the
Archdiocese of Galveston-Houston, the sponsoring parish (its pastor, youth ministry leader, principal, other
agents, etc.) or any representatives associated with the scheduled activity unless the parties involved were
careless and negligent.

*In signing this form I certify that all information contained herein is true and accurate to the best of my
knowledge.*

Signature (Parent/Guardian) _____ Date _____

YOUTH PARTICIPANT: In signing the line below I agree to abide by any/all policies and rules
established for this event. Should I not be able to maintain the guidelines and expectations of the adults and
my peers, I understand that there will be consequences for my actions, including being removed from the
activity and being sent home at my parent's expense.

Signature (Youth Participant) _____ Date _____

VIDEO/PHOTOGRAPHY CONSENT - **REQUIRED**

As parent/guardian, I understand that promotional pictures and videos (individual and group) will be taken
during this event. I give permission for my son's/daughter's picture to be used for promotional materials
(newsletter, web page, calendars, power point, video, etc.) in highlighting the event.

Signature (Parent/Guardian) _____ Date _____

**PLEASE COMPLETE BOTH PAGES OF THIS FORM AND LEAVE NO BLANKS!!!
If an item is not applicable, write "N/A"**

MEDICAL CONSENT FORM**Participant Name:** _____**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.

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 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: _____

Administer: _____

Initial next to ONE of the following:

_____ I hereby **Grant Permission** for nonprescription medication (such as Tylenol, Benadryl, throat lozenges, cough syrup, etc.) (Initial) _____ to be administered to my child if deemed advisable. I understand that Aspirin will not be given to my son/daughter.

_____ I hereby **Do Not Grant Permission** for medication of any type (prescription or nonprescription) to be administered to (Initial) _____ my child unless the situation is life-threatening and emergency treatment is required.

Medical Conditions Information: (Personnel will take reasonable care to see that the following information will be held in confidence.)

My son/daughter has:

Had an episode of the following or has been diagnosed: SEIZURES ASTHMA DIABETIC

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

Has had a 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 also be aware of these special medical and/or psychological conditions of my child (e.g. depression, A.D.D., etc): _____

Insurance Information: **No, my child does not have medical insurance at this time.**

Insurance Carrier: _____ Name of Insured: _____

Insurance Policy Number: _____

Father's Name: _____ Phone: (____) _____

Mother's Name: _____ Phone: (____) _____

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). I fully understand the foregoing statements and sign this Parental/Guardian Medical Consent Waiver knowingly, freely, and willingly.

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

PLEASE COMPLETE BOTH PAGES OF THIS FORM AND LEAVE NO BLANKS!!!

If an item is not applicable, write "N/A"