HOLY SPIRIT PARISH
PARENTAL CONSENT FORM

WHAT:

WHERE:

WHEN:

TIME:

COST:

NAME: _____ **PHONE:** _____

ADDRESS: _____

I, the parent/guardian of _____who is less than eighteen years of age, hereby request that my son/daughter be allowed to participate with the Holy Spirit Parish on the above event or activity. I hereby assume all risk of accident or harm arising or growing out of, directly or indirectly, any incident of any kind occurring during the course of such program to my child and do hereby release and discharge the Bishop of the Diocese of Youngstown, and the agents, associates, and employees of the aforementioned who have organized or participated in the supervision of such program from all claims, demands, suits, causes of actions, rights, costs, expenses, and any compensations whatsoever which may occur to my family and its member during or resulting from participating in the program mentioned. I understand that by signing this Parental Consent Form I am authorizing the Holy Spirit Parish Director of Religious Education or other adult leader, to obtain the services of licensed Emergency Medical Technicians and/or licensed Physicians in the event of a medical emergency involving my son/daughter, and that I will be notified as soon as possible in the event of any such emergency.

Does your son/daughter have any health problems or other special needs which should be brought to the Director of Religious Education's attention? If so, please describe them below:

_____

_____

PARENT'S SIGNATURE _____

DATE _____ **PHONE #** _____

OVER
(Complete Both Sides)

Medical Information *(Please check and sign only those in accordance with your wishes.)*

____ In the event of an emergency, I hereby grant permission to transport my son/daughter and obtain emergency medical or surgical treatment from a licensed physician, hospital, or medical clinic. I hereby authorize medical personnel to release necessary information about my care to Anne Weeks of Holy Spirit Parish and/or parish group leader. I wish to be advised prior to further treatment by the hospital or doctor. In the event I cannot be reached, please contact _____ at _____. Relationship to youth: _____.

Family physician _____ Phone _____

(*Please check one of the following)*

_____ My son/daughter is covered by hospitalization and medical insurance under policy # _____ issued by_____.

_____ My son/daughter does not have medical coverage and I assume responsibility for the cost of Hospitalization and medical care for my son/daughter.

Signature: _____ Date: _____

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_____ I hereby warrant that to the best of my knowledge, my son/daughter is in good health. **I do not want any medical treatment to be given to my son/daughter under any circumstances.** I hereby assume all responsibility for the health and well being of my son/daughter and release from responsibility the Bishop of the Diocese of Youngstown, and Holy Spirit Parish, and the agents, associates, and employees of the Bishop and parish who have organized or participated in the supervision of such program.

Signature: _____ Date: _____

_____ My son/daughter is taking medications at present. He/she will bring all such medications necessary and such medications will be well labeled. The names of, and concise directions for taking such medications, including dosage and frequency of dosages are as follows: _____

Signature: _____ Date: _____

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

Signature: _____ Date: _____

_____ I hereby grant permission for nonprescription medication (such as acetaminophen, decongestant, cough syrup) to be given to my son/daughter, if requested by my son/daughter and deemed advisable by an adult chaperone.

Signature: _____ Date: _____

_____ I wish to inform you of the following additional medical information and the recommended course of action (allergies, dietary restrictions, special conditions, etc.) _____

_____

Signature: _____ Date: _____

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_____ I would like to have the Holy Spirit Parish group leader speak with me further regarding a medical concern or situation. Please contact me at _____.