

Catholic Parish of St. John the Baptist

School/Parish Year: 2008 through 2009

Confirmation 2010 Deadline is March 18, 2010 noon

OFF-SITE CONSENT AND WAIVER FORM for RE/YOUTH ACTIVITIES

This Form is required from all youth for trips/activities, including field trips, outside your local area (more than sixty (60) miles from your church or school). It must be used for all overnight trips.

Name of Activity (hereinafter referred to as the Activity and more fully described below). (Please print)

Participant's Name: Birth Date: Age: Girl/Boy:

Address: City/State: Zip:

Home Telephone: ()

Participant resides with (check all that applies): Mother Father Guardian(s)

Custodial Parent/Legal Guardian's Name:

Home Address: City/State: Zip:

Home Telephone: () Business () Cell ()

Emergency Contact: Relationship:

Home Telephone: () Cell: ()

Second Contact: Relationship:

Home Telephone: () Cell: ()

PARTICIPATION PERMISSION: I, the undersigned, am custodial parent/legal guardian of Participant and request that he/she be to allowed participate in the Confirmation Retreat, March 27-28,2010 9:00 am Saturday to 11:00 am Sunday at Our Lady of Guadalupe Camp, Luther, OK including travel time and all events and activities related to said Activity. Transportation is being provided by Parents. I understand that in the event Participant fails to conduct herself/himself in a manner consistent with the policies of the Catholic Parish of St. John the Baptist she/he may be requested to leave the Activity and return home at my expense and that additional disciplinary action may result.

LOST OR STOLEN ITEMS: I hereby understand and agree that neither the Archdiocese of Oklahoma City or (Parish/School Name) nor any of their respective employees, directors, officers, agents, representatives and/or volunteers shall be held liable for any of my or my child's personal property lost or stolen during participation in the Activity.

MEDICAL INFORMATION: Is Participant taking any medications OR have any medical conditions (e.g., diabetes, epilepsy, heart conditions, etc.) yes no If yes, explain (attach additional sheets as necessary):

Does your child have any allergies? (e.g., insects, hay fever, strawberries, peanuts, etc.) yes no If yes, explain (attach additional sheets as necessary):

Does your child have any allergies or adverse reactions to medications? (e.g., penicillin, ibuprofen, acetaminophen, etc.) yes no If yes, explain (attach additional sheets as needed):

Does your child have any disabilities or physical or developmental limitations? yes no If yes, explain (attach additional sheets as necessary):

Date of last tetanus immunization:

Participant's Primary Physician: Telephone: ()

Health Plan Carrier:

Group#: Policy#:

Name of primary insured:

(Parent Initial)

REQUEST AND AUTHORIZATION TO ADMINISTER MEDICINES: I request and authorize the staff of the Activity to administer the medicines listed below to Participant, as indicated:

	<u>Name of Medicine</u>	<u>Dosage</u>	<u>Frequency</u>
1.	_____		
2.	_____		

NOTE: ALL MEDICINES TO BE TAKEN OR ADMINISTERED MUST BE ARRANGED FOR IN ADVANCE AND MUST BE PROVIDED IN THEIR ORIGINAL PHARMACY CONTAINER, INCLUDING THE PARTICIPANT'S NAME AND DOCTOR'S INSTRUCTION. (Attach extra pages if necessary)

I hereby **grant** _____ **do not grant** _____ permission for non-prescription medication (such as non-aspirin products, i.e., acetaminophen or ibuprofen, throat lozenges, etc) to be given to Participant, if deemed appropriate.

Parent/Guardian Signature: _____ **Date** _____

CONSENT TO TREATMENT OF PARTICIPANT: I am the custodial parent or legal guardian of Participant. I hereby warrant that to the best of my knowledge, Participant is in good health and physically able to participate in the Activity and I assume all responsibility for the health and physical condition and ability of Participant to so participate. In the event of circumstances that indicate that Participant is in need of immediate medical care, I authorize and give permission for Participant to be transported to a hospital/clinic/medical facility for evaluation and emergency medical or surgical treatment, including any necessary X-ray examination. I authorize any licensed physician or medical center to treat Participant. **I accept full responsibility for any medical or hospital bills associated with the care of Participant.**

Photo Consent: I grant _____ do not grant _____ permission to use my child's photo for this event. Some may be posted on the web site but no last names are ever used.

LIABILITY WAIVER: In consideration of the arrangement set forth herein, I do on behalf of myself, Participant and our respective heirs, successors, assigns and next of kin, release, waive, hold harmless, defend and covenant **NOT TO SUE, *Catholic Parish of St. John the Baptist***, the Archbishop of the Archdiocese of Oklahoma City, and the Archdiocese of Oklahoma City and each of their respective departments, directors, administrators, teachers, officers, agents, representatives, volunteers and employees from any and all actions, claims, demands or liabilities, including without limitation, those for personal injuries or property damage, that I and/or Participant may suffer due to illness or injury suffered by Participant as a result of, or in connection with, participation in the Activity, including the administration of authorized medications, medical treatment and any consequences that may arise as the result of said treatment, including without limitation, travel to and from the Activity, housing, meals and collateral entertainment to the fullest extent permitted by law.

I certify to you that the information contained herein is true and correct to the best of my knowledge and that I fully understand the terms and legal consequences of my execution of this OFF-SITE CONSENT AND WAIVER FORM FOR YOUTH consisting of two (2) pages.

SIGNATURE:

Custodial Parent/Guardian Name (please print): _____

Custodial Parent/Guardian Signature: _____ **Date** _____