This form is to be used for all young people through age 18. FORM A

OFFICE OF YOUTH MINISTRY AND YOUNG ADULT MINISTRY
DIOCESE OF VICTORIA IN TEXAS PERMISSION FORM/MEDICAL RELEASE
St. Joseph Church Vacation Bible School

NAME_____ Grade student is entering _____
Address_____ City_____
St/Zip_____ Phone (____) _____ Gender_____
Age _____ Birthdate_____ Parish_____

PARENT/LEGAL GUARDIAN'S NAME_____
Address (if different than above) _____
Phone (____) _____Cell (____) _____Wk (_____)_____

I request and give my consent for my son/daughter, _____ to participate in all church sponsored activities from **Mon. July 9, 2018** through **Fri. July 13, 2018**, sponsored by **St. Joseph Catholic Church/Parish in Yoakum, TX** and/or by the Diocese of Victoria. I understand that my son/daughter will be under the supervision of diocesan and/or parish personnel. As parent or legal guardian I agree to defend, indemnify and hold harmless the Diocese of Victoria and **St. Joseph Catholic Church/Parish in Yoakum, TX**, its clergy, officers, agents, employees and volunteers from any claims, costs or expenses for property damages, personal injuries or other damages arising out of my son/daughter's participation in the above mentioned activity or during the transportation to and from the event. I grant permission for non-prescriptive medication (e.g. tylenol, throat lozenges, cough syrup, pepto-bismol, etc.) and routine nonsurgical medical care to be given to my son/daughter if deemed advisable by the supervising diocesan personnel. In case of an emergency, I also grant permission to transport my child to the nearest hospital for emergency medical or surgical treatment and for an authorized adult sponsor to sign for treatment if I cannot be located. I hereby give permission for my son/daughter to be photographed or videotaped. I realize that the photo maybe published in the newspaper, a magazine, or other publication. The video may be used for educational purposes or informational purposes regarding programs or curriculum.

_____ _____
Date Parent's Signature

Family Physician_____ Phone(_____)_____
Address_____City/State/Zip_____
My son/daughter is allergic to:_____
My son/daughter takes the following medication (name, dosage):_____
This medication is for:_____
Medication that my son/daughter is allergic to:_____
Last immunization/booster for Diphtheria/Tetanus:_____
Any specific medical problems:_____ Any physical limitations:_____
In an emergency, if unable to reach parent/guardian, please contact:
Name_____Work Phone (_____)_____Home Phone (____)_____
Name_____Work Phone (_____)_____Home Phone (____)_____
Name of Insurance Company_____
Phone (____)_____
Address_____
City/St/Zip_____
_Name of Insured_____ Policy
#_____ Group or Plan
#_____