

Catholic Diocese of Shreveport and/or the Parish of _____

Parental Liability Waiver, Permission and Medical Information

Youth Participant's Name: _____
Birth Date: _____ Sex: _____
Parent/Guardian/Conservator Name: _____
Home Address: _____
City: _____ State: _____ Zip: _____
Cell Phone _____ Home Phone _____ Office Phone _____
Emergency Contact Name: _____
Relationship to the son/daughter/participant: _____
Home Phone: _____ Business Phone: _____
Cell Phone: _____ Texting: Yes No

Release/Indemnification Information:

I, _____ grant my permission for _____
Parent/Guardian/Conservator's Name Participant's Name

to participate with the various programs and activities of the Diocese of Shreveport and/or the parish of _____ beginning the 1st day of June, 2016 and continuing through the 31th day of May, 2017. These various programs and activities will take place under the guidance and direction of employees and/or volunteers from the parish of _____ and/or the Diocese of Shreveport. This permission and liability waiver will be kept on file and will accompany the child on any and all programs and activities of the Diocese of Shreveport and/or parish of _____. A separate FORM 2 Youth Travel Permission Form must be filled out and turned in to accompany this form per each program and/or activity.

I understand that as parent/guardian/conservator, I remain legally responsible for any personal actions taken by the participant named above.

I agree on behalf of myself, my son/daughter/participant named herein, our/his/her heirs, successors, and assigns to hold harmless, the Diocese of Shreveport, the Bishop and his successors, employees, agents, volunteers, the Parish, its employees and volunteers from any and all claims (unless due to gross negligence of the Diocese and/or Parish) for illness, injury, death and the cost of medical treatment therewith, arising from or in any way connected with my son's/daughter/participant's attending the various programs and activities during the dates named above.

In the event any legal action is taken by either party against the other party to enforce any of the terms and conditions of this agreement, it is agreed that that each party is responsible for its own legal fees, court costs and expenses.

Parent/Guardian/Conservator Signature Date

- Promotional Release

I also consent to the use of any videotapes, photographs, slides, audiotapes, or any other visual or audio reproduction (in perpetuity unless otherwise revoked by me in writing and delivered by certified mail, return receipt requested, to: The Catholic Center, 3500 Fairfield Ave, Shreveport, LA 71104. ATTN: Director of Youth Ministry) in which my son/daughter may appear by the Diocese of Shreveport. I understand that these materials, including websites and social media sites, are being used for promotion of the youth ministry of the Diocese of Shreveport which may include recruitment and fundraising efforts.

Parent/Guardian/Conservator Signature Date

FORM 1 ANNUAL YOUTH ENROLLMENT FORM page 2 of 3

Social Media Release

The Diocese of Shreveport utilizes today’s technology in a positive way to reach out to the youth of the Diocese, including Facebook email, and other social media. We may remove any content deemed inappropriate. All communications with any youth through social media programs by anyone representing the Diocese may be made available to any parent upon request. If you do not allow your son/daughter to text, Facebook, or use other social media, there will no expectation that they do so in order to participate in certain youth ministry events. However, the Diocese cannot guarantee that photos, videos or other communications of your son/daughter from diocesan and/or parish events will not be uploaded to a social media site.

⇒ **Parent/Guardian/Conservator Signature** _____ **Date** _____

Is the participant insured? Yes No

If yes, please fill out the information below FROM THE PARTICIPANTS Insurance Card,:

Name of Policy Holder (whose name is the policy in) _____

Insurance Carrier/Name of Insurance Co: _____

Policy Number: _____ Insurance ID Number: _____

Claim Address/Zip _____

Customer Service Phone # _____

Medications: Check All that Apply – Note: DO NOT CHECK ALL BOXES BELOW AS ONE MAY CANCEL OUT ANOTHER

- This child takes no medication and will bring no medication with him/her.
- This child takes medication/s and will self-medicate. The child will bring all such medications necessary, and such medications will be clearly labeled. I understand that the child will be required to turn all medication(s) over to a supervising adult designated to keep medication(s). I further understand that it will be this child’s responsibility to present himself/herself at a location designated for returning medication(s) to this child at the frequencies/times listed below. I understand that the adult to whom this child surrenders the medication has no medical training and this adult will not measure dosages. This child will return the medication(s) to the adult after he/she self-medicates. At the conclusion of the event it will be this child’s responsibility to pick up remaining medication(s), if any, at the self-medication designated location. Names of medications and exact dosage and frequencies/times are as listed below: (you may attach a sheet to this form if you need more space just make sure to sign and date it as well).

- This child takes medication but is unable to self-medicate. The child’s parent/guardian/conservator will provide and dispense any and all needed medications.

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

- I grant permission for the following nonprescription medication to be given to this child (excluding medication listed below that causes allergic reaction) in the recommended dosage on the medication bottle.

Non-aspirin pain reliever:	Yes	No
Throat Lozenge:	Yes	No
Decongestant:	Yes	No
Antacid:	Yes	No
Antihistamine:	Yes	No

Specific Medical Information

1.Allergic reactions (medications, foods, plants, insects, etc.):

2.Other Medications child currently takes

3.Date of last tetanus injection *(Without a date, one may be given in the event of an accident.)*

4.Any physical limitations

5.Has child recently been exposed to contagious disease or condition such as mumps, measles, chicken pox, etc.? If so, date and disease or condition.

6.You should also be aware of these special medical conditions of this child:

To the best of my ability, everything I have stated here is true and accurately reflects my wishes.

⇒ **Parent/Guardian/Conservator Signature** _____ **Date** _____