

# Parent/Guardian Permission and Liability Waiver

## Description of Activity/Event: Life Teen Mountain Retreat 2011

Date(s): September 2-5, 2011

Type of Event: High School Retreat to Camp Kahdalea in Brevard, NC

Destination: Camp Kahdalea, 2500 Morgan Mill Rd., Brevard, NC 28712 (828) 884-6834

Individual In Charge: Jennifer Kam (St. John the Beloved) and Sue Crance (Youth Minister – St. Theresa the Little Flower)

Mode of Transportation: Approved Volunteer Drivers

## Participant Information:

Participant's Name: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_

Parent/Guardian's Name \_\_\_\_\_

Full Address: \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ Business Phone: ( ) \_\_\_\_\_

## Permission to Participate:

I, \_\_\_\_\_, grant permission for my son/daughter, \_\_\_\_\_  
*Parent or Guardian's Name* *Child's Name*

to participate in this parish youth ministry event, that requires transportation to a location away from the parish site. This activity will take place under the guidance and direction of Parish employees and/or volunteers from St. John the Beloved Catholic Church.

## Hold Harmless Agreement:

As parent/legal guardian, I remain legally responsible for any personal actions taken by my son/daughter named above.

I agree on behalf of myself, my son/daughter named herein, our heirs, successors, and assigns to hold harmless and defend St. John the Beloved Catholic Church, its officers, directors, agents, and the Diocese of Charleston from any liability for illness, injury or death arising from or in connection with my son's/daughter's attending the above named event, and I agree to compensate the parish, its officers, directors and agents, and the Diocese of Charleston, or representatives associated with the event for reasonable attorney's fees and expenses arising in connection therewith.

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

## Permission To Be Photographed:

I give my permission for my child, \_\_\_\_\_, to be photographed at this event and understand that the photographs may be used for publicity, etc. \_\_\_ Yes \_\_\_ No

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Side A

## MEDICAL CONSENT AND PERMISSION TO TREAT

**Release of Information:**

To the best of my knowledge, my child, \_\_\_\_\_ is in good health, and I assume all responsibility for the health of my child. In the event of an emergency, I give permission to transport my child to a hospital for emergency treatment. I wish to be advised prior to any further treatment by the hospital or doctor.

I hereby grant medical personnel permission to release medical information to the Diocesan Director and/or my parish youth minister in the event that my youth becomes ill or injured.

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

**Please include a copy of your insurance card, front and back.**

Insurance Carrier: \_\_\_\_\_ Policy Number: \_\_\_\_\_

**Emergency Contact Information:**

Parent/Guardian's Name: \_\_\_\_\_

Full Address: \_\_\_\_\_

Home Phone: (    ) \_\_\_\_\_ Business Phone (    ) \_\_\_\_\_

If you are unable to reach me, please contact:

Name: \_\_\_\_\_

Relationship to me or my son/daughter: \_\_\_\_\_

**Medical History:**

My son/daughter is under the care of a psychiatric/psychologist. \_\_\_\_\_ Yes \_\_\_\_\_ No

Name: \_\_\_\_\_ Phone Number: (    ) \_\_\_\_\_

Please explain: \_\_\_\_\_

My son/daughter is taking medication and will bring all medication with him/her and it will be clearly labeled. My son/daughter is taking the following medication(s) and directions for taking this medication, including dosage, frequency and storage are as follows: \_\_\_\_\_

I hereby grant permission for non-prescription medication (such as cough drops, cough syrup, Tylenol, etc.) To be given to my child if necessary. \_\_\_\_\_ Yes \_\_\_\_\_ No

My son/daughter is allergic to the following: \_\_\_\_\_

My son/daughter's immunizations are current and up to date \_\_\_\_\_ Yes \_\_\_\_\_ No

My son/daughter has the following limitations: \_\_\_\_\_

My son/daughter experiences homesickness, emotional reactions to new situations, sleepwalking, fainting, bedwetting, etc. \_\_\_\_\_ Yes \_\_\_\_\_ No

Please explain: \_\_\_\_\_

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

**Side B**