Diocese of Corpus Christi

Office of Evangelization and Catechesis

Our Lady of the Assumption – Ingleside, TX

PARENTAL/GUARDIAN CONSENT, LIABILITY

PHOTOGRAPHY/VIDEOGRAPHY CONSENT

Important! To be filled out by the Parent/Guardian for youth under 18 years of age.
If participant is 18 years of age or older, consent must be signed by the individual)

I (name of parent/guardian) _____ , grant _____ permission for my child, (participant's name-list all children/youth on religious education form) _____

_____

_____ , to participate in _____ to be held _____

_____

I agree on behalf of myself, my child's other parent if known or living (name of parent) _____ my child named herein, or our heirs, successors, and assigns, to release and hold harmless and defend the Diocese of Corpus Christi, the sponsoring parish (its pastor, youth minister, principal, volunteers, other agents, etc.) or any representatives associated with the scheduled activity from all damages, claims, suits, expenses and payments for injury to my child and/or property, including all damages, claims, suits, expenses and payments resulting from the negligence of the Diocese of Corpus Christi, and parish, and/or their officers, directors, volunteers, and employees.

As parent/guardian, I understand that promotional pictures (individual and group) will be taken during this event. I give permission for my son's/daughter's picture to be used for promotional materials (newsletter, web page, calendars, power point, video, etc.) **in highlighting the event.**

_____ _____

Signature (Parent/Guardian) **Date**

_____ _____

Signature (Participant 18 years of age or older must sign own consent) **Date**

MEDICAL CONSENT

Please complete one per child/teen

Medical Matters

I hereby warrant to the best of my knowledge, my child is in good health, and I assume all responsibility for the health of my child. Of the following statements pertaining to medical matters, sign only those in accordance with your wishes:

Emergency Medical Treatment

In the event of an emergency, I hereby give permission to transport my child to a hospital for emergency medical or surgical treatment. I wish to be advised prior to any further treatment by the hospital or doctor.

In the event of an emergency and you are unable to reach me, contact:

Name & Relationship: _____ Phone: _____

Medications:

Family Doctor: _____ Phone: _____

My child will bring all such medications, well labeled, that are necessary. Names of medications and concise directions for seeing that the child takes such medications, including dosage and frequency are as follows:

Medication(s): _____ Dosage _____

Administer: _____

_____ I hereby **Do Not Grant Permission** for medication of any type, whether prescription or nonprescription may be administered by my child unless the situation is life threatening and emergency treatment is required. (Please initial)

_____ I hereby **Grant Permission** for nonprescription medication (such as Tylenol, throat lozenges, cough syrup) to be given to my child, if deemed advisable. I understand that Aspirin will not be given to my son/daughter. (Please initial)

Medical Conditions Information

(Diocesan personnel will take reasonable care to see that the following information will be held in confidence.)

My son/daughter has had an episode of the following or has been diagnosed: ☐ Siezures ☐ Asthma ☐ Diabetic

Allergic reactions to the following (foods, dyes, latex etc.) _____

Has had a medical surgery within the last six months? ☐ Yes ☐ No Still under doctor's care? ☐ Yes ☐ No

Has a medically prescribed diet? _____

The following physical limitations? _____

Immunizations current and up to date: ☐ Yes ☐ No Date of last tetanus/diphtheria immunization _____

You should also be aware of these special medical conditions of my child: _____

Insurance Information

(Please attach a copy of the Insurance Card, front and back, with this form)

Insurance Carrier: _____

Name of Insured: _____

Insurance Policy Number: _____

Father's Name: _____ Day Phone: _____

Mother's Name: _____ Day Phone: _____

In the event it comes to the attention of the chaperones associated with the activity that my child becomes ill with repeated symptoms such as headache, vomiting, sore throat, fever, diarrhea, I want to be called immediately. If this will be a long distance call, I want to be called collect (with phone charges reversed to myself).

I fully understand the foregoing statements and sign this Parental/Guardian Medical Consent Waiver knowingly, freely, and willingly.

_____ _____

Signature (Parent/Guardian) **Date**

_____ _____

Signature (Participant 18 years of age or older must sign own consent) **Date**