

**Archdiocese of Dubuque Teens Encounter Christ
Parental/Guardian Consent Form and Liability Waiver**

Participant's name: _____

Birth date: _____ Gender: _____

Parent/Guardian's name: _____

Home address: _____

Home phone: _____ Business phone: _____

I, _____, grant permission for my child,

Parent or Guardian's Name

_____ to participate in this Archdiocesan

Name of Child

event that requires transportation to a location away from the school/parish site. This activity will take place under the guidance and direction of school/parish employees and/or volunteers

of _____ and the Archdiocese of Dubuque.

Name of Host Site

I agree on behalf of myself, my child named herein, or our heirs, successors, and assigns, to hold

harmless and defend _____, its officers, directors

Name of Host Site

and agents, and the Archdiocese of Dubuque, chaperones, or representatives associated with the event, arising from or in connection with my child attending the event(s) or in connection with any illness or injury or cost of medical treatment in connection therewith, and I agree to compensate the parish, its officers, directors and agents, and the Archdiocese of Dubuque, chaperons, or representative associated with the event for reasonable attorney's fees and expenses arising in connection therewith.

Signature: _____ Date: _____

MEDICAL MATTERS: I hereby warrant that 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 that are applicable.

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, if you are unable to reach me at the above numbers, contact:

Name & relationship: _____ Phone: _____

Family doctor: _____ Phone: _____

Family Health Plan Carrier: _____ Policy #: _____

Signature: _____ Date: _____

(over)

Other Medical Treatment: In the event it comes to the attention of the parish/school, its officers, directors and agents, and the Archdiocese of Dubuque, chaperons, or representatives associated with the activity that my child becomes ill with symptoms such as headache, vomiting, sore throat, fever, diarrhea, I want to be called.

Signature: _____ Date: _____

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

Signature: _____ Date: _____

I hereby grant permission for non-prescription medication (such as aspirin, throat lozenges, cough syrup) to be given to my child, if deemed appropriate.

Signature: _____ Date: _____

Specific Medical Information: The parish/school will take reasonable care to see that the following information will be held in confidence.

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

Does child have a medically prescribed diet? _____

Any physical limitations? _____

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

