ARCHDIOCESE OF DENVER

RISK MANAGEMENT PROPERTY/CASUALTY INSURANCE TRUST

RETURN COMPLETED FORM TO PARISH/SCHOOL/ECCLESIASTICAL ORGANIZATION

PARENTAL/GUARDIAN CONSENT FORM AND LIABILITY WAIVER

Name of Minor ("Participant"): _____

Home Address: _____

_____

Home Phone: _____ Business Phone: _____

Parent(s)/Guardian(s) Name(s): _____

I/we, _____
Parent(s) Or Guardian(s) Name

grant permission for my/our child, _____
Participant's Name

to participate in this parish/school/organization activity. This activity will take place under the employees and/or volunteers guidance and direction of

_____.
Parish/School/Organization Name (Print)

A brief description of the activity follows:

Type of event: _____

Location(s): _____

Individual(s) in charge: _____

Duration of activity: _____

Mode of transportation to and from event: _____

_____

_____

As parent(s) and/or legal guardian(s), I/we remain legally responsible for any personal actions taken by the above-named Participant.

I/We further agree to defend, indemnify and hold harmless the Parish/School/Organization and the Archdiocese of Denver as well as any of its affiliated agencies and their respective agents, directors, officers, employees, and volunteers from any and all claims or demands made for damage, loss, illness or injury to the above-named Participant.

Signature: _____ Date: _____
Parent Or Guardian

Signature: _____ Date: _____
Parent Or Guardian

MEDICAL MATTERS

The Parish/School/Organization will take all reasonable and prudent care to see that confidentiality regarding the following information is maintained.

I/We hereby warrant that to the best of my/our knowledge, my/our child is in good health, and I/we assume all responsibility for the health of my/our child. I/We understand and acknowledge that any medical expenses related to illness or injury to my/our child are not covered by any insurance program maintained by the Parish/School/Organization or the Archdiocese of Denver, and that I/we am/are responsible for such expenses.

Emergency Medical Treatment: In the event of an emergency, I/we hereby give permission to transport my/our child to a hospital for emergency medical or surgical treatment. I/we 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/us at the above numbers, contact:

_____

Name of Minor ("Participant"): _____

Sex: _____ Birth Date: _____

Name of Parent(s)/Guardian(s): _____

Emergency Phone(s): _____

Family doctor: _____ Phone: _____

Family Health Plan Carrier: _____

Policy #: _____

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

_____

Immunizations: Date of last tetanus/flu immunization: _____

Does Participant have a medically prescribed diet? _____

_____

Any physical limitations? _____

Has Participant recently been exposed to contagious disease or conditions, such as mumps, measles, flu, chickenpox, etc.? If so, date and disease or condition:

_____

_____

Other special medical conditions:

_____

_____

Medications: Participant is taking medication at present.

Yes ☐ No ☐

It is Participant's responsibility to bring all necessary medications, and to ensure they are clearly labeled. Instructions from the Participant's family physician for these medications must be attached to this form. The instructions must include the name, concise dosing directions, purpose of, and proper storage of and for all medications.

NOTE: Parish/School/Organization staff and volunteers WILL NOT administer ANY medications requiring the use of a syringe or other needle delivery system. Alternate accommodations for must be made for these circumstances and the parish/school/organization fully informed of the nature of such accommodations.

Notice: I want to be contacted in the event it comes to the attention of the parish/school/organization, its officers, directors and agents, and the Archdiocese of Denver, chaperones, or representatives associated with the activity that Participant experiences symptoms such as headache, vomiting, sore throat, fever, diarrhea, etc.

Yes ☐ No ☐

I/We hereby grant permission for the following non-prescription medication (non-aspirin products such as acetaminophen or ibuprofen, throat lozenges, cough syrup, etc.) to be administered to the Participant, if deemed appropriate.

Yes ☐ No ☐

_____

_____

_____

OR: 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.

Yes ☐ No ☐

Signature: _____ Date: _____
Parent Or Guardian

Signature: _____ Date: _____
Parent Or Guardian