

Each student must have this form completed.

DIOCESE OF VICTORIA IN TEXAS
YOUTH PERMISSION FORM/MEDICAL RELEASE

NAME _____ Gender _____ Grade _____
Address _____ City _____ State/Zip _____ Age _____
Home Phone _____ Birth date _____ Parish _____ Holy Cross, East Bernard _____

PARENT/LEGAL GUARDIAN'S NAME _____
Address (if different than above) _____ Phone (if different than above) _____
Phone (____) _____ Cell (____) _____ Wk (____) _____

I hereby consent to participation by my son/daughter, _____ in the ALL church sponsored activities from August 1, 2018 through July 31, 2019, sponsored by Holy Cross Catholic Church and/or the Dioceses of Victoria in Texas. I understand that my son/daughter will be under the supervision of diocesan and/or parish personnel. As parent or legal guardian I agree to defend, indemnify and hold harmless the Diocese of Victoria and Holy Cross Church, its' clergy, officers, agents, employees, and volunteers from any claims, costs or expenses for property damages, personal injuries or other damages arising out of my son/daughter's participation in the above mentioned activities. I grant permission for non-prescriptive medication (e.g. Tylenol, throat lozenges, cough syrup, Pepto-Bismol, etc.) and routine nonsurgical medical care to be given to my son/daughter if deemed advisable by the supervising diocesan personnel. In case of an emergency, I also grant permission to transport my child to the nearest hospital for emergency medical or surgical treatment and for an authorized adult sponsor to sign for treatment if I cannot be located. I hereby give permission for my son/daughter to be photographed or video taped. I realize that the photo maybe published in newspaper, a magazine, power point presentations or other publication. The video may be used for educational purposes or informational purposes regarding programs or curriculum.

_____ Date _____ Parent's Signature _____

Family Physician _____ Phone _____
Address _____ City/State/Zip _____

My son/daughter is allergic to: _____
My son/daughter takes the following medication (name, dosage): _____
This medication is for: _____
Medication that my son/daughter is allergic to: _____
Last immunization/booster for Diphtheria/Tetanus (date): _____ Any specific medical problems: _____ Any physical limitations: _____
_____ Other concerns that we need to be aware of: _____

In an emergency, if unable to reach parent/guardian, please contact:

Name _____ Work Phone (____) _____ Home Phone (____) _____
Name _____ Work Phone (____) _____ Home Phone (____) _____

Name of Insurance Company _____ Phone (____) _____
Address _____ City/State/Zip _____
Name of Insured _____ Policy # _____
Group or Plan # _____