

# Diocesan Youth Conference (DYC) Permission Slip

Dear Parent or Legal Guardian: Your son/daughter, guardianship is eligible to participate in a diocesan-sponsored activity that requires personal transportation to locations away from your home site. This activity will take place under the guidance and supervision of adult chaperones. A brief description of the activity follows:

**ACTIVITY:** 47th Annual Diocesan Youth Conference, April 26th – 28th; Ridgecrest Conference Center, Black Mountain, NC

**DESIGNATED SUPERVISOR OR ACTIVITY:** Paul Kotlowski, Parish Youth Ministers, & parish chaperones

**TEEN'S FULL NAME:** \_\_\_\_\_ **GENDER:** MALE FEMALE **GRADE:** \_\_\_\_\_

**ADDRESS (w/ City & Zip):** \_\_\_\_\_

**PARENT NAMES:** \_\_\_\_\_ **PHONE # (during wknd):** \_\_\_\_\_

**EMERGENCY CONTACT:** \_\_\_\_\_ **PHONE # (during wknd):** \_\_\_\_\_

**CURRENT MED INFORMATION:** Please describe any current conditions NOT outlined on your HEALTH FORM.

**In the Event of an illness, I grant permission for a staff member to administer the following OTC drugs (initial all that apply):**

Ibuprofen (Advil)  Acetaminophen (Tylenol)  Anti-Biotic Ointment (Neosporin)  Anti-Histamine (Benadryl)  Antacids (Rolaids/Tums)  Other: \_\_\_\_\_

**Accident/Hospitalization Policy Name:** \_\_\_\_\_ **Policy Number:** \_\_\_\_\_

As parent, or legal guardian, you remain fully responsible for any legal responsibility which may result from any personal actions taken by the child. If you would like your child to participate in this event, please complete, sign and return the following statement of consent and release of liability. As parent, or legal guardian, you remain fully responsible for any legal responsibility, which may result from any personal actions taken by the named child.

I hereby consent to participation by my child in the event described above. I understand that this event will take place away from parish grounds and that my child will be under the supervision of the designated supervisor on the stated dates. I further consent to the conditions stated above on participation in this event, including the method of transportation.

I give my permission for my child, in case of an emergency, to be taken to a physician or hospital by either the supervisor in charge or by an adult chaperone. I understand that every effort will be made to contact me. If I cannot be reached, however, I hereby give permission to the physician selected by the supervisor in charge or adult chaperone(s) to hospitalize and secure proper treatment (including surgery) for my son/daughter. The cost of any necessary medical care or treatment for my son/daughter will be my expense.

If your youth brings or uses any drugs, alcohol, weapons, or tobacco products or engages in reckless or violent behavior, you will be expected to retrieve your son/daughter from the trip immediately. Authorities may be notified.

Photographs or videotape of participants may be used in publications, websites, or other materials produced from the Office of Youth Ministry, Diocese of Charlotte, or St. Thomas Aquinas.

By checking this box, I/We notify the Diocese of Charlotte that our child(ren) is not to attend any presentation, workshop or talk involving the topic of human sexuality.

\_\_\_\_\_  
Parent's or Legal Guardian's Signature

\_\_\_\_\_  
Date

# Health Form

(Completion required for final registration)

PLEASE RETURN FORM AT REGISTRATION:

NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_  
ADDRESS \_\_\_\_\_ FEMALE \_\_\_\_\_ MALE \_\_\_\_\_  
\_\_\_\_\_ DIOCESE of CHARLOTTE

Is this participant in general good health and able to participate in all normal activities?  
YES \_\_\_\_\_ NO \_\_\_\_\_ (If not, please submit a statement indicating limitations.)

Please give date of most recent physical examination.  
DATE: \_\_\_\_\_ FAMILY PHYSICIAN(S) OR CLINIC: \_\_\_\_\_  
ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_

\* \* \* \* \*

Immunization History GIVE DATES PLEASE:  
DPT \_\_\_\_\_ DPT BOOSTER \_\_\_\_\_ TETANUS BOOSTER \_\_\_\_\_  
POLIO SERIES \_\_\_\_\_ POLIO BOOSTER \_\_\_\_\_

Allergies (Please write yes or no next to each)  
HAY FEVER \_\_\_ ASTHMA \_\_\_ SULFA \_\_\_ FAINTING \_\_\_ POISON IVY \_\_\_  
CONVULSIONS \_\_\_ PENICILLIN \_\_\_ BEE STING \_\_\_ FOOD ALLERGIES \_\_\_\_\_  
OTHER \_\_\_\_\_

List Current Medications being taken and Current Medical Condition:  
\_\_\_\_\_  
\_\_\_\_\_

If any of the above are yes, please submit a statement of how the child has been treated and with what medication. Submit a statement of any other medications currently in use and what for. This and any other medication will be dispensed by the Director of the program.

Operations or Serious Injury w/ Dates: \_\_\_\_\_  
Please notify the office if this child is exposed to any communicable disease during the three weeks prior to program attendance.

\* \* \* \* \*

In signing this application, I hereby certify that the above information is correct and give permission for my child to be transported in privately owned vehicles to and from public transportation or for approved out-of-program activities; and for the release of medical records to an attending physician in case of illness.

In case of medical emergency, I understand that every effort will be made to contact parents or guardian of participants. In the event that I cannot be reached, I hereby give permission to the physician selected by the Program Director to hospitalize, secure proper treatment for and to order injection, anesthesia or surgery for my child, as named herein.

SIGNATURE OF PARENT/GUARDIAN: \_\_\_\_\_ DATE \_\_\_\_\_  
Telephone During Program: \_\_\_\_\_ Alternate Phone # \_\_\_\_\_  
Family Health Insurance Co.: \_\_\_\_\_ Policy # \_\_\_\_\_