Permission & Health Form

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: Triad Youth Day, June 1, 2024; Greensboro Science Center, Greensboro, North Carolina

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 #_____