St. Peter the Apostle Catholic Church Youth Permission Form
Parental/Guardian Consent Form and Liability Waiver

Participant's Name:____
Birth Date:___________**Sex:**___**Parent/Guardian's Name:**___________________________
Address:____
Home Phone:___________________________**Daytime Phone:**______________________

I,____________________________, **grant permission for my child,** _____________________________
(Parent or guardian's name) **(Child's name)**
to participate in this youth ministry event with St. Peter's Church in Park Rapids.

Type of event: Confirmation Retreat
Location of event: Northern Pines Camp, Park Rapids
Individual in charge: Annette Haas, Youth Ministry / Faith Formation Director
Date/Time of event: Saturday, March 3 – Sunday, March 4, 2018

As a parent and/or legal guardian, I remain legally responsible for any personal actions taken by the above named minor (participant). I agree on behalf of myself, my child named herein, or our heirs, successors, and assigns, to hold harmless and defend St. Peter the Apostle Catholic Church, its officers, directors and agents, chaperones, or representatives associated with the event, damages arising from or in connection with my child attending the event or in connection with any illness or injury or cost of medical treatment in connection therewith, and I agree to compensate St. Peter the Apostle Catholic Church, its officers, directors and agents, chaperones, or representatives associated with the event for any 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 statement 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 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 for more)

Other Medical Treatment:

In the event it comes to the attention of St. Peter the Apostle Catholic Church, its officers, directors and agents, chaperones, 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:**__________________________

Medication:

My child is taking medication at present. My child will bring all such medications necessary, and such medications will be well labeled. **My child will be responsible for taking his/her medication, and letting adult leader know that they have done so.** Names of medications and concise directions for such medications, including dosage and frequency of dosage, are as follows:

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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:**__________________________

Special Medical Information:

St. Peter the Apostle Catholic Church will take reasonable care to see that the following information will be held in confidence.

Allergic reactions (medication, foods, plants, insect, etc.):

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Any physical limitations? ____

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

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