

# Catholic Diocese of Sioux Falls

## Overnight Youth Event Parental/Guardian Consent Form and Liability Waiver

Event Name: \_\_\_\_\_ Event Date(s): \_\_\_\_\_

Event Location: \_\_\_\_\_ Event Host: \_\_\_\_\_

Participant's name: \_\_\_\_\_ Parish \_\_\_\_\_

Address: \_\_\_\_\_  
Street/PO Box \_\_\_\_\_ City/State \_\_\_\_\_ Zip \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: F M T-Shirt Size: S M L XL XXL Grade in School: \_\_\_\_\_

Parent/Guardian's name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home phone: \_\_\_\_\_ Alt phone: \_\_\_\_\_ School Attending \_\_\_\_\_

Email Address: \_\_\_\_\_  Please add me to the youth events email list

I, \_\_\_\_\_, grant permission for my child, \_\_\_\_\_  
Parent or Guardian's Name Child's Name

to participate in the camp experience(s) marked above during the corresponding dates of the activity and at the location listed above, understanding that if said event requires transportation to a location away from the parish site, such activity will take place under the guidance and direction of event employees.

As 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, and our heirs, successors, and assigns, to hold harmless and defend the Catholic Diocese of Sioux Falls, the sponsoring organizations, and the hosting organizations, their officers, directors and agents, chaperones, and representatives associated with the event, 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 the parish, its officers, directors and agents, and the Catholic Diocese of Sioux Falls, chaperones, and representative associated with the event for reasonable attorney's fees and expenses arising in connection therewith.

I hereby give permission for images of my child, captured during the above named event, through video, photo and digital camera, to be used solely for the purposes of promotional material and publications within the Catholic Diocese of Sioux Falls, and waive any rights of compensation or ownership thereto.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Parent or Guardian's Name (required)

**Medical Health:** I hereby warrant that to the best of my knowledge, my child, the above named "participant", is in good health, and I assume all responsibility for the health of my child.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Parent or Guardian's Name (required)

**Complete both sides of this form and mail with the appropriate payment to the event organizer.**

*In the following information boxes containing statements pertaining to medical health, sign only those which are applicable to the participant.*

**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 further treatment by the hospital or doctor. In the event of an emergency, if you are unable to reach me at the numbers previously given for the parent/guardian, contact:

Name & Relationship to participant: \_\_\_\_\_ Phone: \_\_\_\_\_

Family Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

Health Plan Carrier: \_\_\_\_\_ Policy #: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Parent or Guardian's Name**

**Medication:**

➤ My child is taking medication at present. My child will bring all such medications necessary, and such medications will be well labeled. Names of medications and concise directions for seeing that the child takes such medications, including dosage and frequency of dosage, are as follows: \_\_\_\_\_  
\_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Parent or Guardian's Name**

➤ 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: \_\_\_\_\_

**Parent or Guardian's Name**

➤ I hereby grant permission for non-prescription medication (such as aspirin, throat lozenges, cough syrup) to be given to my child, if deemed by camp staff to be necessary and appropriate.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Parent or Guardian's Name**

**Specific Medical Information:** *Reasonable care will be taken to see that the following information is held in confidence.*

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

Immunizations: Date of last tetanus/diphtheria immunization: \_\_\_\_\_

Does the child have a medically prescribed diet? \_\_\_\_\_

Any physical limitations? \_\_\_\_\_

Is child subject to chronic homesickness, emotional reactions to new situations, sleepwalking, fainting \_\_\_\_\_  
\_\_\_\_\_

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

Other special medical conditions: \_\_\_\_\_  
\_\_\_\_\_