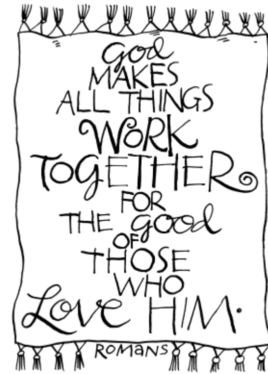
Youth Ministry & Faith Formation Permission Slip



TITLE OF POLICY: PARENTAL/LEGAL GUARDIAN PERMISSION FORM

POLICY NO. 5360
Revised 9/15/95 Revised 9/10/11 Revised 5/23/16

DIOCESE OF CHARLOTTE, NC
PARENTAL/LEGAL GUARDIAN PERMISSION 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:

ACTIVITIES: Youth Ministry and/or Confirmation activities for the year including but not limited to: Fall and Spring Re-treats, CROP WALK, March for Life, off-site service projects, 30-Hour Famine, scavenger hunts, canned food collections, and other off-campus youth oriented actives throughout the year.

DESIGNATED SUPERVISOR OR ACTIVITY: Susan Rabold and qualified adult leaders and chaperones

If you would like your child to participate in these events, 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 events described above. I understand that these events may take place away from parish grounds and that my child will be under the supervision of one of the designated supervisors on the stated dates. I further consent to the conditions stated above on participation in these events, 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.

___________________________________ ____________________

Parent's or Legal Guardian's Signature Date

Phone number where you can be reached in case of emergency_________________________________

Accident/Hospitalization Policy Name ____

Policy Number: ____

Confirmation & SPY Health Form

(Completion required for final registration)

PLEASE RETURN FORM AT REGISTRATION:

NAME ________________________________
ADDRESS _____________________________
____

DATE OF BIRTH ________________________
FEMALE ___________ MALE ____________
DIOCESE 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 ___________ OTHER _____________
CONVULSIONS __________ PENICILLIN ___________ ___________________
BEE STING ______________ 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 ____
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 outof-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 #_______________

(SEE BACK FOR ADDITIONAL INFORMATION)

* If your teen is taking any medication at any events please describe any side-effects we should be aware of, eating/drinking instructions, etc. Also in this space please disclose any health or behavioral concerns we should be aware of with your teen.

* Please CIRCLE any item(s) below that you give St. Paul's permission to administer to your teen upon their request. We will administer them in accordance with the label directions. If you have specific instruction on administration of these medications, please disclose them on this sheet. We will do our best to contact you prior to administration of any approved items and we will follow up with you regarding the administration of any of the below items.

Tylenol
Extra-strength Tylenol
Advil
Ibuprofen
Aleve
Tums
Rolaids
Mylanta
Neosporin
Pamprin or Midol
Benadryl tablet
Benadryl ointment (or similar anti-itch products)
Cough syrup
Cough drops
Throat lozenges

* Please provide any other information we may need to know here:

____ Signature Here
____ Print Name Here