

**OFFICE OF YOUTH MINISTRY AND YOUNG ADULT MINISTRY
DIOCESE OF VICTORIA IN TEXAS
St. Joseph Church, Moulton, Texas
PERMISSION FORM/MEDICAL RELEASE**

NAME _____ Sex _____ Grade _____

Address _____ City _____

St/Zip _____ Phone (____) _____

Age _____ Birthdate _____ Parish _____

PARENT/LEGAL GUARDIAN'S NAME _____

Address (if different than above) _____

Phone (____) _____ Cell (____) _____ Wk(____) _____

I request and give my consent for participation by my son/daughter, _____ to participate in all church sponsored activities from **August 1, 2015 through August 1, 2016** sponsored by St. Joseph Church, Moulton, Texas or the Diocese of Victoria. I understand that my son/daughter will be under the supervision of diocesan and/or parish personnel. As parent or legal guardian I agree to defend, indemnify and hold harmless the Diocese of Victoria, its clergy, officers, agents, employees and volunteers from any claims, costs or expenses for property damages, personal injuries or other damages arising out of my son/daughter's participation in the above mentioned activity or during the transportation to and from the event. I grant permission for non-prescriptive medication (e.g. tylenol, throat lozenges, cough syrup, pepto-bismol, etc.) and routine nonsurgical medical care to be given to my son/daughter if deemed advisable by the supervising diocesan personnel. In case of an emergency, I also grant permission to transport my child to the nearest hospital for emergency medical or surgical treatment and for an authorized adult sponsor to sign for treatment if I cannot be located.

____ **(Please initial for consent) Photo Disclaimer:** I hereby give permission for my child to be photographed. I realize that the photo maybe published in the newspaper, magazine, or other publication.

_____ Date _____ Parent's Signature _____

Family Physician _____ Phone (____) _____

Address _____ City/State/Zip _____

My son/daughter is allergic to: _____

My son/daughter takes the following medication (name, dosage): _____

This medication is for: _____ Medication that my son/daughter is allergic to: _____

Any specific medical problems: _____ Any physical limitations: _____

In an emergency, if unable to reach parent/guardian, please contact:

Name _____ Work Phone (____) _____ Home Phone (____) _____

Name _____ Work Phone (____) _____ Home Phone (____) _____

Name of Insurance Company _____ Phone (____) _____

Address _____

City/St/Zip _____

Name of Insured _____ Policy # _____

Group or Plan # _____