

PARENTAL/GUARDIAN CONSENT FORM AND LIABILITY WAIVER

Participant's Name: _____

Birth date: _____ Sex: _____

Parent/Guardian's name: _____

Home address: _____

Home phone: _____ Business phone: _____

I, _____ grant permission for my child,
Parent or guardian's name

_____ to participate in this **MQP Youth Ministry** event that
Child's name
requires transportation to a location away from the parish/location site. This activity will take place under the guidance and direction of parish employees and/or volunteers from Mary, Queen of Peace parish. A brief description of the activity follows:

Type of event: _____

Destination of event: _____

Individual in charge: _____

Date of departure and return: **Arrival:** _____
Pick Up: _____

Mode or transportation to and from event: _____

****Included Activities:** _____

As parent and/or legal guardian, I remain legally responsible for any personal actions 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 Mary, Queen of Peace, its officers, directors and agents, and the Archdiocese of New Orleans, chaperons, or 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/location, its officers, directors and agents, and the Archdiocese of New Orleans, chaperons, or representative associated with the event for 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 statements 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 further 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 and relationship: _____ Phone: _____
Family doctor: _____ Phone: _____
Family Health Plan Carrier: _____ Policy #: _____

Signature: _____ Date: _____

Other Medical Treatment: In the event it comes to the attention of the parish/location, its officer, directors and agents, and the Archdiocese or New Orleans, chaperons, 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 collect (with phone charges reversed to myself).

Signature: _____ Date: _____

Medications: 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: _____

No medication of any type, whether prescription or nonprescription, 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: _____

Specific Medical Information: The parish/location will take reasonable care to see that the following information will be held in confidence.

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

Immunizations: _____

Date or last tetanus/diphtheria immunization: _____

Does child have a medically prescribed diet? _____

Any physical limitations? _____

Is child subject to chronic homesickness, emotional reactions to new situations, sleepwalking, bedwetting, fainting? _____

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

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