

**ARCHDIOCESE OF NEW ORLEANS
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, _____, to participate in this parish activity that may require transportation to a location away from the parish site. This activity will take place under the guidance and direction of employees and/or volunteers from _____ Parish. A brief description of the activity follows:

Type of event: World Youth Day: New Orleans

Location(s): Loyola University, New Orleans, LA

Individual in charge: Megan Scardina- Youth Minister

Duration of activity: 7:30am (drop-off at church) - 6:30pm (pick-up at church)

Mode of transportation to and from event: School Bus provided (drop off in front of church)

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, or our heirs, successors, and assigns, to hold harmless and defend Our Lady of the Lake Parish, its officers, directors and agents, and the Archdiocese of New Orleans, coaches, 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, its officers, directors and agents, and the Archdiocese of New Orleans, coaches, chaperons, or representatives associated with the activity for reasonable attorney's fees and expenses arising in connection therewith.

Signature: _____ Date: _____

ARCHDIOCESE OF NEW ORLEANS
MEDICAL INFORMATION AND CONSENT FORM

GENERAL INSTRUCTIONS TO PARENTS/GUARDIANS:

1. Please take care in filling out this form. It provides crucial information for caregivers in the event of illness or medical emergency. Accuracy and thoroughness are encouraged.
 2. Sections I, II and V are mandatory. Sections III and IV provide you with treatment options in non-emergency situations.
-

Participant's name: _____

Birth date: _____ Sex: _____

Parent/Guardian's name _____

Home address: _____
(Street) (City/State) (Zip)

Home phone: _____ Cellular phone: _____

Business phone: _____ Other: _____

SECTION I. MEDICAL MATTERS

As the parent/legal guardian of the above named child, who is currently associated with Our Lady of the Lake Parish. I hereby authorize Megan Scardina or his/her assistants to carry out the wishes I have named (herein) in areas of emergency medical treatment and other cases of illness. This authorization inclusively extends from July, 2010 through June, 2011. 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.

Signature: _____ Today's Date: _____

SECTION II. 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 listed herein, contact:

Name & relationship: _____

Phone: _____ Family doctor: _____ Phone: _____

Family Health Plan Carrier: _____ Policy #: _____

Signature: _____ Date: _____

SECTION III: OTHER MEDICAL TREATMENT

In the event it comes to the attention of the parish, its officers, directors and agents, and the Archdiocese of New Orleans, 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 collect (with phone charges reversed to myself).

Signature _____ Date: _____

SECTION IV: MEDICATIONS

(SIGN ONLY THOSE OPTIONS THAT ARE APPLICABLE)

- 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: _____

- 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: _____

- 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: _____

SECTION V: MEDICAL INFORMATION

The parish will take reasonable care to see that the following information will be held in confidence.

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

Immunizations: Date of 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, bed-wetting, 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: _____

ADULT LIABILITY WAIVER

In addition to the Medical Information and Consent form, each adult participant, including group leaders and chaperons, must sign this form.

RELEASE OF LIABILITY

I, _____, agree on behalf of myself, my heirs, assigns,
Full Name

executors, and personal representatives, to hold harmless and defend Our Lady of the Lake Parish, the Archdiocese of New Orleans, its officers, directors, agents, employees, or representatives associated with the activity listed below from any and all liability claims, loss or damage arising from or in connection with my participation in the activity listed below.

Type of event: World Youth Day: New Orleans

Destination of event: Loyola University New Orleans

Sponsoring Agency: Youth Group

Estimated time of departure and return: 7:30am-6:30pm

Mode of transportation to and from event: School Bus Provided

Signature

Date

Print Name

ADULT MEDICAL INFORMATION AND CONSENT FORM

GENERAL INSTRUCTIONS:

1. Please take care in filling out this form. It provides crucial information for caregivers in the event of illness or medical emergency. Accuracy and thoroughness are encouraged.
2. Sections I, II and V are mandatory. Sections III and IV provide you with treatment options in non-emergency situations.

Participant's name: _____

Birth date: _____ Sex: _____

Home address: _____
(Street) (City/State) (Zip)

Home phone: _____ Cellular phone: _____

Business phone: _____ Other: _____

SECTION I. MEDICAL MATTERS

I hereby authorize Megan Scardina- Youth Minister or his/her assistants to carry out the wishes I have named (herein) in areas of emergency medical treatment and other cases of illness. This authorization inclusively extends from July, 2000 through June, 2001.
(Date) (Date)

I hereby warrant that, to the best of my knowledge, I am in good health, and I assume all responsibility for my health care.

Signature: _____ Today's Date: _____

SECTION II. EMERGENCY MEDICAL TREATMENT

In the event of an emergency, I hereby give permission to be transported to a hospital for emergency medical or surgical treatment. In the event of an emergency contact:

Name & relationship: _____

Phone: _____ Family doctor: _____ Phone: _____

Family Health Plan Carrier: _____ Policy #: _____

Signature: _____ Date: _____

(Over)

SECTION III: MEDICATIONS

I understand that I am responsible for taking my own medications and that such medications will be kept in well-labeled containers. Names of medications and concise directions for such medications, including dosage and frequency of dosage, are as follows:

Signature: _____ Date: _____

SECTION V: MEDICAL INFORMATION

The parish/group coordinator will take reasonable care to see that the following information will be held in confidence.

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

Immunizations: Date of last tetanus/diphtheria immunization: _____

Do you have a medically prescribed diet? _____

Any physical limitations? _____

Are you subject to chronic homesickness, emotional reactions to new situations, sleepwalking, bed-wetting, fainting?

Have you recently been exposed to contagious disease or conditions, such as mumps, measles, chickenpox, etc? If

so, date and disease or condition: _____

I have the following special medical condition that you should be aware of: _____
