

Permission/Medical Release Form

This Section to be filled out by parish:

Event Name: _____

Event Location: _____

Designated Supervisor of Event: _____

Date & Time of Departure: _____

Date & Anticipated Time of Return: _____

Method of Transportation: _____

Cost of Event: _____

Brief Description of Event: _____

This section to be filled out by parent/guardian of participant:

Participant's Name: _____

Address: _____

City, State, ZIP: _____

Tele #: _____

Parent(s)/Guardian(s) name(s): _____

I hereby consent to participation by my son/daughter in the event described above. I understand that this event will take place away from the Parish grounds and that my child will be under the supervision of the above-mentioned supervisor on the stated date(s). I further consent on the conditions stated above on participation in this event, including the method of transportation. As parent/legal guardian, I remain fully responsible for any legal responsibility for the actions taken by the named student. I hereby hold harmless _____ parish, the Diocese of Madison, its officers, directors, and agents, and all employees and chaperones associated with the event. In the event of an emergency, I hereby give permission to transport my child to a hospital for emergency medical treatment or surgery.

Parent's (Guardian's) Signature: _____ Date: _____

A medical form must be completed and on file.

Date form is completed: ___/___/___

Medical Form

Student's Name: _____ Date of Birth: ___/___/___

Home Address: _____ City: _____

State: _____ ZIP: _____ Home Telephone #: (_____) _____

School: _____ Grade: _____ Sex: ___ Male ___ Female

Parent(s)/Guardian(s) Name: _____

Mother (Guardian) Work tele #: _____ Cell Phone #: _____

Father (Guardian) Work tele #: _____ Cell Phone #: _____

Emergency Contact (other than parent):

Name: _____ Relation to student: _____

Home Telephone #: _____ Work/Cell Telephone #: _____

Student's Doctor: _____ Telephone #: (_____) _____

Family Health Plan Carrier: _____ Policy #: _____

Medication:

My child is taking the following medications: _____

My child has the following allergies (medications, foods, plants, insects, etc.): _____

Any physical limitations? ___ Yes ___ No (if yes, please explain on back or on separate sheet)

Any other special medical condition? ___ Yes ___ No (if yes, please explain on back or on separate sheet)

If appropriate, my child may be given (please initial):

Tylenol: ___ Yes ___ No; Ibuprofen: ___ Yes ___ No

I have completed this form to the best of my ability. To my knowledge, all of the above information is accurate.

Parent/Guardian Signature: _____ Date: _____

This Medical Form must be updated annually – or when the information contained on this form has changed.