

## Parent/Guardian Permission and Liability Waiver

**Description of Activity/Event:** Middle School Retreat 6th to 8th Grade

Date(s): 01/29/2022 to 01/30/2022

Type of Event: Catholic Middle School Youth Retreat

Arrival/Departure Time: 0730 from St. Theresa's returning afternoon on Sunday

ER Phone Number: (843) 560-0653

Destination: Camp St. Christopher, Seabrook Island, SC 29455

Individual In Charge: Richard White

Mode of Transportation: 15 Pass. MFSAB

### Participant Information:

Participant's Name: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_

Parent/Guardian's Name \_\_\_\_\_

Full Address: \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ Business Phone: ( ) \_\_\_\_\_

**Adult Shirt Size:**    \_\_\_ S    \_\_\_ M    \_\_\_ L    \_\_\_ XL    \_\_\_ 2X    \_\_\_ 3X

### Permission to Participate:

I, \_\_\_\_\_, attest that I am the parent or legal guardian of this participant,

*Parent or Guardian's Name*

and I grant permission for my child, \_\_\_\_\_ to participate

*Child's Name*

in this parish youth ministry event, which requires transportation to a location away from the parish site. This activity will take place under the guidance and direction of Parish employees and/or volunteers from \_\_\_\_\_.

*Parish Name*

### Hold Harmless Agreement:

As parent/legal guardian, I agree to be legally responsible for any personal actions taken by my son/daughter named above. In the event of a serious violation of the rules of conduct, I understand that he/she may be sent home at my expense, but you will be notified and logistics discussed with you in advance.

I agree on behalf of myself, my son/daughter named herein, our heirs, successors and assigns to indemnify, hold harmless and defend \_\_\_\_\_,

*Parish Name*

and the Diocese of Charleston, their officers, directors and agents (collectively, the "Diocesan Parties") from any liability for illness, injury or death arising from or in connection with my son/daughter attending the above named activity/event, except that such obligations shall not apply in the event of the gross negligence or intentional acts of the Diocesan Parties.

*Signature of Parent/Guardian:* \_\_\_\_\_ *Date:* \_\_\_\_\_

### Permission To Be Photographed:

I give my permission for my child, \_\_\_\_\_, to be photographed at this event and understand that the photographs may be used for publicity, etc.    \_\_\_ Yes    \_\_\_ No

*Signature of Parent/Guardian:* \_\_\_\_\_ *Date:* \_\_\_\_\_

Side A

## MEDICAL CONSENT AND PERMISSION TO TREAT

### **Release of Information:**

To the best of my knowledge, my child, \_\_\_\_\_ is in good health, and I assume all responsibility for the health of my child. In the event of an emergency, I give permission to transport my child to a hospital or emergency treatment facility. I wish to be advised prior to any further treatment by the medical professionals, but I do not want treatment to be withheld if neither I nor any emergency contact I have named below can be located and the injury is life-threatening or the failure to provide treatment is likely to result in permanent injury.

I hereby grant medical personnel permission to release medical information to the Diocesan Director and/or my parish youth minister in the event that my child becomes ill or injured.

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

### **Insurance Information:**

Insurance Carrier: \_\_\_\_\_ Policy Number: \_\_\_\_\_

### **Emergency Contact Information:**

Parent/Guardian's Name: \_\_\_\_\_

Full Address: \_\_\_\_\_

Home Phone: (    ) \_\_\_\_\_ Business Phone (    ) \_\_\_\_\_

If you are unable to reach me, please contact:

Name: \_\_\_\_\_

Relationship to me or my son/daughter: \_\_\_\_\_

### **Medical History:**

My son/daughter is under the care of a medical provider. \_\_\_\_\_ Yes    \_\_\_\_\_ No

Provider Name: \_\_\_\_\_ Phone Number: (    ) \_\_\_\_\_

My son/daughter is taking medication and will bring all medication with him/her and it will be clearly labeled. My son/daughter is taking the following medication(s) and directions for taking this medication, including dosage, frequency and storage are as follows:

I hereby grant permission for non-prescription medication (such as cough drops, cough syrup, Tylenol, etc.) To be given to my child if necessary. \_\_\_\_\_ Yes    \_\_\_\_\_ No

My son/daughter is allergic to the following: \_\_\_\_\_

My son/daughter's immunizations are current and up to date \_\_\_\_\_ Yes    \_\_\_\_\_ No

My son/daughter has the following limitations: \_\_\_\_\_

My son/daughter experiences homesickness, emotional reactions to new situations, sleepwalking, fainting, bedwetting, etc. \_\_\_\_\_ Yes    \_\_\_\_\_ No

Please explain: \_\_\_\_\_

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

**Side B**