

Parent/Guardian Permission and Liability Waiver

Description of Activity/Event: Retreat

Date(s): Sunday, March 29, 2020

Type of Event: **Confirmation Retreat at Camp Long**

Arrival/Departure Time: 8am Meet at St. Angela Hall, Parents arrive at camp on Sunday at 4:30 pm

ER Phone Number: Joan LaBone, Youth Director 803-215-7040

Destination: Camp Long, 82 Camp Long Rd, Aiken, SC (off of Wire Rd.)

Individual In Charge: Joan LaBone, Youth Director, St, Mary Help Of Christians Parish

Mode of Transportation: Church Bus, Chaperon Car

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, _____, grant permission for my son/daughter, _____
Parent or Guardian's Name *Child's Name*

to participate in this parish youth ministry event, that 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 St. Mary Help of Christians Parish.

Parish Name

Hold Harmless Agreement:

As parent/legal guardian, I remain legally responsible for any personal actions taken by my son/daughter named above.

I agree on behalf of myself, my son/daughter named herein, our heirs, successors, and assigns to hold harmless and defend St. Mary Help of Christians Parish,

Parish Name

its officers, directors, agents, and the Diocese of Charleston from any liability for illness, injury or death arising from or in connection with my son's/daughter's attending the above named activity/event.

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 for emergency treatment. I wish to be advised prior to any further treatment by the hospital or doctor.

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 youth 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