

**WAIVER, RELEASE, AND MEDICAL INFORMATION  
CATHOLIC DIOCESE OF EVANSVILLE**

Youth's Name \_\_\_\_\_ Age \_\_\_\_\_ Grade \_\_\_\_\_

School/Church \_\_\_\_\_ City \_\_\_\_\_

Event \_\_\_\_\_ Date(s) of Event \_\_\_\_\_

I/We, the parent(s) of the above-named youth, hereby give my/our approval for his/her participation in the above event. I/We assume all risks and hazards incidental to the conduct of the activities and transportation to and from the event. I/We do further hereby waive, release, absolve, indemnify and hold harmless the Bishop of the Catholic Diocese of Evansville, Holy Rosary Parish, or Angie Fleck and any of their respective affiliates, successors, agents, employees, members, and representatives, adult sponsors, and other volunteers involved in the activities and transportation associated with the event from any and all claims, including claims of personal injury to my/our youth or property damage, under any theory of law (including negligence, but not reckless or intentional conduct) in any way resulting from or arising in connection with the activities and/or transportation to and from the event.

Father's or Mother's Signature **X** \_\_\_\_\_ Date \_\_\_\_\_

Guardian's Signature **X** \_\_\_\_\_ Date \_\_\_\_\_

**EMERGENCY INFORMATION**

Family Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_

Contact Father at \_\_\_\_\_ Cell # \_\_\_\_\_

Contact Mother at \_\_\_\_\_ Cell # \_\_\_\_\_

Contact Guardian at \_\_\_\_\_ Cell # \_\_\_\_\_

If Guardian cannot be reached, call:

Name \_\_\_\_\_ Phone \_\_\_\_\_

Family Physician \_\_\_\_\_ Phone \_\_\_\_\_

Hospital Preference \_\_\_\_\_

Are parents living together? Yes or No With whom does the child live? \_\_\_\_\_

-Is there anyone who by court order or decree is designated as the primary or sole custodial parent?  
\_\_\_\_\_

-NAME anyone who has been restrained from picking up the child? \_\_\_\_\_

**I UNDERSTAND IT IS MY RESPONSIBILITY TO KEEP THE YOUTH MINISTER INFORMED ABOUT SUCH MATTERS AND TO PROVIDE COPIES OF RELEVANT COURT ORDERS AND DECREES TO OFFICIALS.**

**PERMISSION SLIP IS NEEDED ANY TIME THE STUDENT LEAVES THE CHURCH PROPERTY.**

**MEDICAL INFORMATION:**

List any chronic or existing disease or medical problems or allergies (e.g. diabetes, epilepsy, peanut allergy)

List any instructions for care of the above if it becomes necessary at event::

List any medications your child is taking on a regular basis: (SEE BELOW)

In case of accident or serious illness I request the Youth Minister to contact me. If I cannot be reached, I hereby authorize the Youth Minister to make whatever arrangements the circumstances allow. It is understood and agreed that neither the Parish, Youth Minister, nor the Catholic Diocese of Evansville is the insurers of my child's health and safety while he/she is at youth functions or engaged in supervised activities, including sports. I understand it to be my obligation to provide such insurance as I may desire to purchase to protect myself and my child against the costs of sickness or injury. If the above named child needs emergency medical treatment, and neither a parent nor the designated family physician can be contacted, consent is hereby granted for such emergency treatment as may be considered necessary in the opinion of the attending physician.

Father or Mother's Signature **X** \_\_\_\_\_ Date \_\_\_\_\_

Guardian's Signature **X** \_\_\_\_\_ Date \_\_\_\_\_

**AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATION BY AUTHORIZED PERSONNEL**

**I HEREBY AUTHORIZE PERSONNEL TO ADMINISTER MEDICATION AS INDICATED TO:**

Name \_\_\_\_\_ Grade \_\_\_\_\_ Youth Minister \_\_\_\_\_

Rx Number \_\_\_\_\_ Name of Medication \_\_\_\_\_

Directions: \_\_\_\_\_

Doctor \_\_\_\_\_ Phone \_\_\_\_\_ Pharmacy \_\_\_\_\_

Time medication is given at home:

Time medication is to be given at the event:

**I give my permission to administer Advil or Tylenol and/or similar products. Yes \_\_\_\_\_ No \_\_\_\_\_**

**I UNDERSTAND THAT MY SIGNATURE RELIEVES THE PARISH PERSONNEL OF ANY AND ALL LIABILITY RELATED TO THE ADMINISTRATION OF THE PRESCRIBED MEDICATION.**

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

Phone number where you may be reached during event: \_\_\_\_\_

**PLEASE TURN IN PERMISSION SLIPS TO THE PARISH OFFICE.**