PARENTAL/GUARDIAN CONSENT FORM/LIABILITY WAIVER -

Participant's name_____ Birth date_____ Age:____ Sex:____

Parent/Guardian name_____

Street Address/City/State/Zip_____

Phone (home)_____(work)_____ (cell)_____

I ask for and grant permission for my son/daughter _____to attend and participate at the _____This activity will take place under the guidance and direction of employees and/or volunteers from the ARCHDIOCESE OF HARTFORD and _____(parish).

Event:

MODE OF TRANSPORTATION:

Estimated time of Departure:

Estimated time of Return:

Person in Charge from Parish:

While youth are responsible for their own behavior and agree to abide by all the rules and regulations established for this event, as parent and/or legal guardian, I remain legally liable for any actions or damages made by the above named minor. I am aware that I will be called if my child breaks any of the rules and has to be sent home. I agree on behalf of myself, my child named herein, our heirs, successors, and assigns to hold harmless and defend the ARCHDIOCESE OF HARTFORD, the parish named above, and their officers, directors, agents, employees, representatives associated with this event from any and all liability claims, loss or damage arising from or in connection with my child attending this event or in connection with any illness or injury or cost of medical treatment in connection therewith. I agree to compensate the above entities for reasonable attorney fees and expenses arising in connection therewith.

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. In the event of an emergency and I can not be reached, I hereby give permission to transport my child to a hospital or medical facility and to seek medical attention. I give permission for the administration of non-prescription medication - aspirin, throat lozenges or cough syrup - if deemed appropriate and if the situation is not life-threatening.

Emergency contact person: Name_____ relationship _____ phone_____
Doctor: Name_____(phone)_____
Insurance: Company_____ Employer _____Group #_____
Subscriber name_____ Subscriber # _____
Date of last tetanus shot:_____ Allergies: (medication, foods, etc)_____
Medications currently taking that may affect treatment: (name dosage)_____
You should also be aware of these special medical /physical/ mental conditions of my child (special diet, sleepwalking, fainting, nose bleeds, recent injuries, exposure to contagious diseases, etc.):

***Please attach a photocopy of the front and back of your insurance card

Parent Signature_____ Print name_____ Date_____

Youth Signature_____ Date_____