

## PARENTAL/GUARDIAN PERMISSION AND RELEASE FOR MINOR VOLUNTEER

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

Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: Male / Female

Last grade completed: \_\_\_\_\_

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

Home Address: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

Email Address(es): \_\_\_\_\_

I, \_\_\_\_\_, grant permission for my son/daughter, \_\_\_\_\_

Parent or Guardian's Name

Child's Name

to participate in this parish sponsored event **Vacation Bible School** on the following dates and

Name of Event

Times: **June 11-15, 2012 9am – 12:15pm.**

Date(s)/Time(s) of Event

This activity will take place under the guidance and direction of parish employees and/or volunteers from **Saint Mary Magdalene Catholic Church.**

Parish Name

T-Shirt size:      YM    YL    YXL    AS    AM    AL    AXL
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**Photograph/Press Release:** I realize that photographs, videos, written extractions, and voice recordings of program participants may be taken during various activities for the purpose of illustrations, publications, and website.

\_\_\_\_\_ I hereby authorize and give full consent to **Saint Mary Magdalene Catholic Church**

Parish Name

to publish and copyright all photographs, videos, written extractions, and voice recordings in which my child appears while participating in **Vacation Bible School**.

Name of Event

\_\_\_\_\_ I do not consent to the photographs, videos, written extractions, and voice recordings release.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

## MEDICAL CONSENT AND PERMISSION TO TREAT MINOR VOLUNTEER

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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.

If you are unable to reach me, please contact:

Name: \_\_\_\_\_ Relationship to my son/daughter: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

My son/daughter is under the care of a psychiatrist/psychologist.

Name of Doctor: \_\_\_\_\_ Phone Number: \_\_\_\_\_

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

My son/daughter is taking medication and will bring all necessary medications with him/her in **its original prescription container\***. My son/daughter is taking the following medication(s) and directions for taking medication, including dosage, frequency and storage are as follows:

\_\_\_\_\_  
\_\_\_\_\_

**\*All Medications will be given to Cindy Roth, DRE to be stored.**

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

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

\_\_\_\_\_

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

\_\_\_\_\_

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

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

I, \_\_\_\_\_ give permission to medical personnel to share information with the  
Parent/Guardian's Name  
DRE in the event of an injury of illness.

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