OFFICE OF FAITH FORMATION
423 HIGHLAND AVE.
FALL RIVER, MASSACHUSETTS 02720
TEL: (508)678-2828 FAX: (508)675-3864

PARENTAL CONSENT, MEDICAL WAIVER, LIABILITY & PHOTO RELEASE AGREEMENT

I _____, the parent/guardian of _____, in consideration
(Print Name of Parent/Guardian) *(Print Name of Child)*
of my request to allow this child the opportunity to participate in **YES! Retreat** located at **Miramar Retreat Ctr.**
(Event Name) *(Location of Event)*
in **Duxburry, MA** on **Fri. 2/8/19 through Sun. 2/10/19**, agree to assume all responsibility associated with this event. I grant
(City/Town and State) *(Date)*

to the Parish of_____, and the Diocese of Fall River, its agents, employees,
(Name of Parish AND City/Town)
and representatives my permission to seek emergency medical attention for this child if, in their judgment, such attention is warranted and I am not immediately available to grant such permission. I agree to be in all ways responsible for any and all expenses associated with any and all medical care furnished to this child.

The Diocese of Fall River has sufficiently explained the nature, extent, and requirements of this event and I am aware of and accept the associated risks of participation in this event. I agree to release and hold the Parish and the Diocese of Fall River and their agents, employees, and representatives, forever harmless and indemnified against and from any and all claims or right of action for damages which my child has or hereafter may acquire either before or after the child has reached majority, including but not limited to all bodily injuries and property damages, and including any legal fees in defending such a claim, resulting from, arising out of, or during, or in any way connected with this event. I also agree to release and hold the Parish and the Diocese of Fall River and their agents, employees, and representatives, forever harmless and indemnified against and from any and all claims or right of action for damages which my child has or hereafter may acquire either before or after the child has reached the majority, including but not limited to all bodily injuries and property damages, and including any legal fees in defending such claim, resulting from, arising out of, or during, or in any way connected with this event.

_____ _____
(Signature of Parent/Guardian) *(Date)*

Emergency Telephone Number(s) where Parent/Guardian can be reached during the event:

(1) (_____)_____; (2) (_____)_____; (3) (_____)_____

Does your child need to administer any ***prescription/ over the counter*** medication during this event? **___ NO ___YES** If yes, please list the medication(s) and their dosages below. Please use the back of this form for additional information.

Medication_____ Dosage_____

Medication_____ Dosage_____

Does your child have any allergies to food and/or medications? **___ NO ___ YES** If yes, please list & explain (use back of form if more space needed)

_____

_____

Participant's Primary Care Physician: _____Physician Phone: _____

Participant's Medical Insurance Company: _____ Policy #_____

PHOTO RELEASE INFORMATION:

I grant to the Diocese of Fall River, its representatives and employees the right to take photographs of my child and his/her property in connection with the above-identified subject. I authorize The Diocese of Fall River, its assigns and transferees to copyright, use and publish the same in print and/or electronically.

I agree that the Diocese of Fall River may use such photographs of child with or without his/her name and for any lawful purpose, including but not limited to such purposes as publicity, illustration, advertising, and Web content.

I have read and understand the above photo release statement. **___ NO ___YES**

_____ _____
(Printed Name of Parent/Guardian) *(Signature of Parent/Guardian)*