PARENTAL/GUARDIAN CONSENT FORM AND LIABILITY WAIVER

Participant's name: ____
Birth date: ____ Sex: _______________________
Parent/Guardian's name: ____
Home address: ____
Home phone________________________ Cell_______________________ Business____________________

I, ______________________________ grant permission for this participant,___________________________
Parent or guardian's name Participant's full name
to participate in this event that requires transportation to a location away from the parish/school site. This activity will take place under the guidance and direction of parish/school employees and/or volunteers from ________________________________.
Name of parish/school

A brief description of the activity follows:
Type of event: Catholic Youth Day
Destination of event: Cathedral Camp, 167 Middleboro Rd, East Freetown, MA 02717
Individual in charge: ____
Estimated time of departure and return: ____
Mode of transportation to and from event: ____

As parent and/or legal guardian, I remain legally responsible for any personal actions taken by the above named participant.

I agree on behalf of myself, this participant named herein, or our heirs, successors, and assigns, to hold harmless and defend ________________________________, the Roman Catholic Bishop of Fall River, Corp Sole,
Name of parish/school
its officers, directors, employees and agents, chaperones, or representatives associated with the event, from any claim arising from or in connection with this participant attending the event or in connection with any illness or injury (including death) or cost of medical treatment in connection therewith, and I agree to compensate the parish/school, the Roman Catholic Bishop of Fall River, Corp Sole, its officers, directors, employees and agents, chaperones, or representatives associated with the event for reasonable attorney's fees and expenses which may incur in any action brought against them as a result of such injury or damage, unless such claim arises from the negligence of the parish/school.

Print Name: ____

Signature: ____ **Date:** _______________________

MEDICAL MATTERS: I hereby warrant that to the best of my knowledge, this participant is in good health, and I assume all responsibility for the health of this participant.

Medical Treatment: In the event that this participant becomes ill with symptoms such as headache, vomiting, sore throat, fever, diarrhea, I want to be contacted at the following phone numbers:
1____________________________ 2____________________________ 3 _____________________________

Emergency Medical Treatment: In the event of an emergency, I hereby give permission to transport this participant to a hospital for emergency medical or surgical treatment. I wish to be advised by the hospital or doctor prior to any further treatment. In the event of an emergency, if you are unable to reach me at the provided numbers, contact:

Name & Relationship: _____________________________________ Phone___________________________
Family Doctor: ____ Phone: __________________________
Family Health Plan Carrier: ________________________________ Policy #: _________________________

Signature: ____ **Date:** ___________________________

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Medications: This participant is taking medication at present. The parent/guardian will ensure medications are well-labeled and will bring such medications and present them to the parish/school. Names of medications and concise directions including dosage and frequency of dosage, are as follows:

Please note: The medication may be administered by someone other than the school nurse, who will be a qualified designee Please sign below to provide your consent

Signature: ____ **Date:** ____________________

Non-Prescription medication: of any type, (i.e. non-aspirin products such as ibuprofen or acetaminophen, throat lozenges, cough syrup):
CHOOSE ONE: ☐ **may** ☐ **may not** be administered to this participant
☐ contact me at the #'s provided before administering

Signature: ____ **Date:** ____________________

Specific Medical Information: The parish/school will take reasonable care to see that the following information will be held in confidence.
Allergic reactions (medications, foods, plants, insects, etc.): ____
Date of last tetanus/diphtheria immunization ____
Does this participant have a medically prescribed diet?____
Any physical limitations? ____
Is this participant subject to homesickness, emotional reactions to new situations, anxiety?
____

Has this participant recently been exposed to contagious disease or conditions, such as mumps, measles, chicken pox, etc.? If so, list date and disease or condition:
____

You should be aware of these special medical conditions of this participant:
____

DFR 09/2020

RELEASE FOR PHOTO/MEDIA RECORDING

I___________________________, the undersigned, do hereby grant permission to __________________________,
Parent or guardian's name | Name of parish/school

the Diocese of Fall River, their representatives and employees to use the image, video and/or audio of my child,

____
Participant's full name

I understand that the decision to use any still images, video and/or audio recording for informational and/or promotional purposes will be made by the aforementioned parish/school/diocese. I also understand that any such still image, video and audio obtained by this same parish/school may be widely shown throughout the Diocese and beyond, including print materials, websites, social media, the internet, and network or cable television, to reach any and all potential targeted audiences.

Signature: ____ **Date:** ____________________

DFR 01/2022