

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: **Twenty96: Youth Event**

Destination of event: St. John of God 1036 Brayton Ave, Somerset, MA 02726

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: _____

PARENTAL/GUARDIAN CONSENT FORM AND LIABILITY WAIVER

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