

East Side Youth Group



OCTOBER 26
5-7PM



COST: \$12
SING UP BY: OCT. 22



FUN/PIZZA/SODA/SKATING/SOCIALIZING

1300 FAIRFIELD DR,

DIOCESAN EVENT WAIVER AND RELEASE
CATHOLIC DIOCESE OF EVANSVILLE (REV. 7/14)

Youth's Name: _____	Age: _____	Grade: _____
Parish /School /Program: _____	City: _____	
Event: _____	Date(s): _____	

I /We, the parent(s) /guardian(s) of the above named youth, hereby give my /our approval for his /her participation in the above event. I /We assume all risks and hazards incidental to the conduct of the activities and transportation to and from the event. I /We do further hereby waive, release, absolve, indemnify, and hold harmless the Bishop of the Catholic Diocese of Evansville,

Parish, _____ Pastor, and any of
their respective affiliates, successors, agents, employees, members, and representatives, adult sponsors, and other volunteers involved in the activities and transportation associated with the event from any and all claims, including claims of personal injury to my /our youth or property damage, under any theory of law (including negligence, but not reckless or intentional conduct) in any way resulting from or arising in connection with the activities and /or transportation to and from the event.

It is understood and agreed that neither the Parish, the Catholic Diocese of Evansville, any respective affiliate, successor, agent, employee, member, representative, adult sponsor, nor other volunteer is the insurer of my child's health and safety while he /she is at youth functions, engaged in supervised activities, including sports, or being transported in association with the event. I /We understand it to be my /our obligation to provide such insurance as I /we may desire to purchase to protect myself /ourselves and my /our child against the costs of sickness or injury.

In case of emergency or serious illness, should the above-named child require medical treatment, and neither a parent nor the designated family physician can be contacted, consent is hereby granted for such medical treatment as may be considered necessary in the opinion of the attending physician.

I UNDERSTAND THAT MY SIGNATURE RELIEVES DIOCESAN AND /OR PARISH
PERSONNEL OF ANY AND ALL LIABILITY RELATED TO THE ADMINISTRATION OF

ANY PRESCRIBED MEDICATION LISTED ON THE DIOCESAN MEDICAL
INFORMATION FORM (INCLUDING OVER-THE-COUNTER DRUGS).

Further, I /we acknowledge having read, or been made aware of the Diocesan Youth and /or Adult Codes of Conduct, the Diocesan Release for Media Recording, and the Diocesan Off-site Transportation Policy, and I /we agree to be bound by the terms and conditions set forth in those documents (copies available via www.evdio.org/diocesan-forms-for-oyaya.html). I acknowledge and understand that any action on behalf of my /our child /dependent that is inconsistent with the Diocesan Code of Conduct may result in appropriate disciplinary action as outlined in those documents.

I represent that I am at least 18 years of age, have read and understand the foregoing statement, and am competent to execute this agreement.

Parent /Guardian Printed Name: _____
Signature: _____ Date: _____

MEDICAL INFORMATION
CATHOLIC DIOCESE OF EVANSVILLE (REV. 7/12)

Youth's Name: _____

Address: _____
(Street) (City, State, Zip)

Parent /Guardian
to Call in Emergency: _____
(Print Name) (Phone)

If Parent /Guardian
CANNOT be reached: _____
(Print Name) (Phone)

Family Physician: _____
(Print Name)

Family Insurance Carrier: _____
(Print Name) (Phone)

Insurance Policy Number: _____

Are parents living together: ☐ Yes. ☐ No.

With whom does child live: ☐ Mother. ☐ Father. ☐ Other: _____

Is anyone, by court order or decree, designated as the sole custodial parent? If so, list:

List anyone restrained from picking up child: _____

I understand it is my responsibility to keep the youth minister informed about such matters and
to provide copies of relevant court orders and decrees to officials.

List any chronic or existing disease or medical problems (e.g. diabetes, asthma, epilepsy):

List any medications your child is taking on a regular basis:

Should it become necessary, please list any instructions for care of the above:

☐

Place "X" in box if it is NOT acceptable for your child to be provided over-the-counter medications (e.g., commonly used pain, allergy, or nausea medications).

Parent /Guardian Signature _____

Date _____