DIOCESE OF STOCKTON -ST. BERNARD CYO MINISTRY
PARENTAL PERMISSION AND HEALTH AUTHORIZATION FORM

MINOR'S NAME _____ PHONE _____

ADDRESS (Street, City, Zip) _____

SCHOOL _____ GRADE _____ BIRTHDATE _____

PARENT/GUARDIAN'S NAME _____ PHONE _____

FULL ADDRESS _____ WORK PHONE _____

PERSON(S) (OTHER THAN PARENT) TO NOTIFY IN CASE OF EMERGENCY:

NAME _____ PHONE _____

I/We, the parent, guardians of the above-named child hereby give my/our permission for his/her participation in any and all Catholic Youth Organization (CYO) activities. I/We agree to direct my/our child to cooperate and conform with directions and instructions of the CYO personnel responsible for CYO activities.

I/We agree that in the event my/our child is injured as a result of his/her participation in CYO activities, including transportation to and from these activities, whether or not caused by the negligence of the CYO Program, the Diocese of Stockton, St. Bernard's Parish, or any of its agents or employees, recourse for the payment of any resulting hospital, medical or related costs and expenses will first be had against any accident, hospital or medical insurance, or any available benefit of mine/ours.

In the event we cannot be reached in an emergency, I/we hereby give permission for:

ADULT LEADER _____ ADULT LEADER _____

to authorize by his/her signature whatever medical treatment may be considered necessary by the attending physician for my/our child.

FAMILY PHYSICAN _____ PHONE _____

ADDRESS _____ CITY/ZIP _____

MEDICAL PLAN _____ PLAN NUMBER _____

IF YOU DO NOT WANT MEDICAL CARE GIVEN TO YOUR CHILD, STATE REASONS: _____

_____

HAVE OR SUBJECT TO (CHECK IF YES):

☐ Asthma ☐ Fainting Spells ☐ Convulsions ☐ Diabetes ☐ Heath Trouble ☐ Allergy or reaction of ANY medication

_____ Sport Restrictions (List) _____

_____ Other (Describe) _____

HAVE DIFFICULTY WITH (CHECK IF YES):

☐ Eyes, Ears, Nose, Throat ☐ Digestion ☐ Lungs ☐ Menstrual Problems

Any condition now requiring medication? _____ Name of Medication _____

Any restriction of activity for medical reasons? _____ Explain _____

_____

The above information is accurate to the best of my/our knowledge,

PARENT/GUARDIAN'S SIGNATURE _____ DATE _____

PARENT/GUARDIAN'S SIGNATURE _____ DATE _____