



# Parental/Guardian Consent Form & Liability Waiver

(This form is required for minors to attend an off property event or trip).

| Applicant Information                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |             |                                                                 |                |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------|-----------------------------------------------------------------|----------------|
| Participant's Name & E-mail Address:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |             |                                                                 | Date of Birth: |
| Address:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |             | City:                                                           | State: Zip:    |
| Home Phone:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |             | Parent/Guardian's Name & E-mail Address:                        |                |
| Cell Phone:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Work Phone: | Other number where Parent/Guardian can be reached during event: |                |
| Consent & Liability Waiver                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |             |                                                                 |                |
| <b>Important! To be filled out by the Parent/Guardian for youth under 18 years of age and individuals age 18 or older and in high school.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |             |                                                                 |                |
| In consideration of the program in which my son/daughter will participate, I, as parent or guardian of my son/daughter, do hereby agree to allow my son/daughter to accompany (entity name) _____ to:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |             |                                                                 |                |
| Event & Location: Peer Ministry 2019-2020 Events                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |             | Date & Time: June 2019-June 2020                                |                |
| <input type="checkbox"/> Transportation Not Provided<br><input checked="" type="checkbox"/> Transportation Provided                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |             | Method of Transportation:                                       |                |
| I acknowledge that (entity name) _____ Holy Cross Catholic Church<br>is providing transportation to and from (location) _____ to the event.<br>I acknowledge and assume the risk of this transportation for my child. My child must comply with (entity name) _____ Holy Cross Catholic Church<br>rules and procedures. By granting this permission, I also waive any claims against, and RELEASE AND HOLD HARMLESS AND INDEMNIFY,<br>(entity name) _____ Holy Cross Catholic Church, the Diocese of Orlando, any of their religious, employees, volunteers, agents<br>and representatives from any liability, claims, demands and causes of action arising out of or relating to any loss, damage or injury sustained in<br>connection with or arising out of my child's participation in the program. |             |                                                                 |                |

|                                                                                                                                 |               |
|---------------------------------------------------------------------------------------------------------------------------------|---------------|
| _____<br>Parent/Guardian Signature<br><i>(must sign for any participant under 18 &amp;/or 18 or older &amp; in high school)</i> | _____<br>Date |
|---------------------------------------------------------------------------------------------------------------------------------|---------------|

**Participant:** In signing the line below, I certify all the information on the trip form is complete and accurate, I also agree to abide by any/all policies established for this event/activity. Should I not be able to maintain the guidelines and expectations of the adults and my peers, I understand there will be consequences for my actions, including being removed from the activity and being sent home at my parents/guardian's expense.

|                                  |               |
|----------------------------------|---------------|
| _____<br>Participant's Signature | _____<br>Date |
|----------------------------------|---------------|

| Insurance Information                                                                                                                              |            |                          |            |
|----------------------------------------------------------------------------------------------------------------------------------------------------|------------|--------------------------|------------|
| <input type="checkbox"/> No, I do not carry medical insurance at this time.<br><input type="checkbox"/> I do carry medical insurance at this time. |            |                          |            |
| Insurance Carrier:                                                                                                                                 |            |                          |            |
| Name of Insured:                                                                                                                                   |            | Insurance Policy Number: |            |
| Father's Name:                                                                                                                                     | Day Phone: | Mother's Name:           | Day Phone: |

In the event the participant does not have insurance, payment in full for medical care becomes the responsibility of the participant's parent/guardian.



# Parental/Guardian Medical Information & Consent Form

| Applicant Information                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |         |                                        |                |      |             |         |             |             |         |             |             |         |             |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|----------------------------------------|----------------|------|-------------|---------|-------------|-------------|---------|-------------|-------------|---------|-------------|
| Participant's Name:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |         |                                        | Date of Birth: |      |             |         |             |             |         |             |             |         |             |
| Address:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |         | City:                                  | State:         | Zip: |             |         |             |             |         |             |             |         |             |
| Father's Name:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |         | Phone:                                 |                |      |             |         |             |             |         |             |             |         |             |
| Mother's Name:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |         | Phone:                                 |                |      |             |         |             |             |         |             |             |         |             |
| Emergency Contact:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |         | Languages Spoken by Emergency Contact: |                |      |             |         |             |             |         |             |             |         |             |
| Medical Matters                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |         |                                        |                |      |             |         |             |             |         |             |             |         |             |
| <p>I hereby warrant to the best of my knowledge, all the information provided is true and correct and I assume all responsibility for the health of my child. I understand it is my responsibility to update the Medical Information &amp; Consent Form if there are any changes to my child's health. <i>(Please initial)</i> _____</p> <p><b>Emergency Medical Treatment:</b> In the event of an emergency, I hereby give permission to transport my child to a hospital/clinic for emergency medical or surgical treatment. <i>(Please initial)</i> _____</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |         |                                        |                |      |             |         |             |             |         |             |             |         |             |
| Family Doctor:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |         | Phone:                                 |                |      |             |         |             |             |         |             |             |         |             |
| <p><b>Medications:</b> I hereby <b>Grant Permission</b> for my child to be given the following provided medications. All medications must be well labeled. [NOTE: Any/all prescription medications must be in original pharmacy container with young person's name on the prescription label. Non-prescription/over-the-counter medications must be in original container with young person's name on the container.] I release and hold harmless (entity name) _____, the Diocese of Orlando and any other religious, employees, volunteers, agents and representatives from any injury or harm resulting from administering the medication.</p> <p><i>(Please initial)</i> _____</p> <p>Names of medications and concise directions for seeing that the child takes such medications, including dosage and frequency, are as follows:</p> <table border="1"> <tr> <td>Medication:</td> <td>Dosage:</td> <td>Administer:</td> </tr> <tr> <td>Medication:</td> <td>Dosage:</td> <td>Administer:</td> </tr> <tr> <td>Medication:</td> <td>Dosage:</td> <td>Administer:</td> </tr> </table>                                                                                                 |         |                                        |                |      | Medication: | Dosage: | Administer: | Medication: | Dosage: | Administer: | Medication: | Dosage: | Administer: |
| Medication:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Dosage: | Administer:                            |                |      |             |         |             |             |         |             |             |         |             |
| Medication:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Dosage: | Administer:                            |                |      |             |         |             |             |         |             |             |         |             |
| Medication:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Dosage: | Administer:                            |                |      |             |         |             |             |         |             |             |         |             |
| <p><b>Medical Conditions Information:</b> (Reasonable steps will be taken to keep this information confidential, but it will be shared with Diocesan personnel and others, as warranted.) My son/daughter:</p> <ul style="list-style-type: none"> <li>Is allergic to the following medications _____</li> <li>Has had an episode of the following or has been diagnosed with: <input type="checkbox"/> Seizures <input type="checkbox"/> Asthma <input type="checkbox"/> Diabetic</li> <li>Has had allergic reactions to the following (foods, dyes, latex, etc.) _____</li> <li>Has had a medical surgery within the last six months? <input type="checkbox"/> Yes <input type="checkbox"/> No      Still under doctor's care? <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>Has a medically prescribed diet <i>(please explain)</i> _____</li> <li>Has the following physical limitations _____</li> <li>Immunizations current and up to date? <input type="checkbox"/> Yes <input type="checkbox"/> No      Date of last tetanus/diphtheria immunization _____</li> <li>You should also be aware of these special medical conditions of my child: _____</li> </ul> |         |                                        |                |      |             |         |             |             |         |             |             |         |             |
| Insurance Information                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |         |                                        |                |      |             |         |             |             |         |             |             |         |             |
| <input type="checkbox"/> No, I do not carry medical insurance at this time.<br><input type="checkbox"/> I do carry medical insurance at this time.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |         | Insurance Carrier:                     |                |      |             |         |             |             |         |             |             |         |             |
| Name of Insured:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |         | Insurance Policy Number:               |                |      |             |         |             |             |         |             |             |         |             |

In the event the participant does not have insurance, payment in full for medical care becomes the responsibility of the participant's parent/guardian.

\_\_\_\_\_  
Parent/Guardian Signature  
*(must sign for any participant under 18 or 18 or older & in high school)*

\_\_\_\_\_  
Date