## Diocese of Corpus Christi - Office of Evangelization and Catechesis

## Parish: Our Lady of the Assumption, Ingleside, Texas

### PARENTAL/GUARDIAN CONSENT, LIABILITY

### PHOTOGRAPHY/VIDEOGRAPHY CONSENT

***Important!*** To be filled out by the Parent/Guardian for youth under 18 years of age.
If participant is 18 years of age or older, consent must be signed by the individual)

I (name of parent/guardian)_____, grant permission for my child, (participant's name-list all children/youth on religious education form)

_____ ,

to participate in OLOA Religious Education to be held on from Sept 2026 to May 2027.

_____.

I agree on behalf of myself, my child/ren's other parent if known or living (name of parent) _____, my child named herein, or our heirs, successors, and assigns, to release and hold harmless and defend the Diocese of Corpus Christi, the sponsoring parish (its pastor, youth minister, principal, volunteers, other agents, etc.) or any representatives associated with the scheduled activity from all damages, claims, suits, expenses and payments for injury to my child and/or property, including all damages, claims, suits, expenses and payments resulting from the negligence of the Diocese of Corpus Christi, and parish, and/or their officers, directors, volunteers, and employees.

**As parent/guardian, I understand that promotional pictures (individual and group) will be taken during this event. I give permission for my son's/daughter's picture to be used for promotional materials** (newsletter, web page, calendars, power point, video, etc.) **in highlighting the event.**

_____ _____

**Signature (Parent/Guardian)** **Date**

_____ _____

**Signature (Participant 18 years of age or older must sign own consent)** **Date**

# Our Lady of the Assumption, Ingleside
# Texas Religious Education Year – 2026-2027

## MEDICAL CONSENT
**Please complete one per child/teen**

**CHILD/TEEN NAME; _ _____**

**Medical Matters**
I hereby warrant to the best of my knowledge, my child is in good health, and I assume all responsibility for the health of my child. Of the following statements pertaining to medical matters, sign only those in accordance with your wishes:

**Emergency Medical Treatment**
In the event of an emergency, I hereby give permission to transport my child to a hospital for emergency medical or surgical treatment. I wish to be advised prior to any further treatment by the hospital or doctor.

In the event of an emergency and you are unable to reach me, contact:

Name & Relationship _____Phone_____

Medications:

Family Doctor _____Phone_____

My child will bring all such medications, well labeled, that are necessary. Names of medications and concise directions for seeing that the child takes such medications, including dosage and frequency are as follows:

Medication(s):_____Dosage: _____
Administer: _____

_____I hereby **Do Not Grant Permission** for medication of any type, whether prescription or nonprescription may be administered by my child unless the situation is life threatening and emergency treatment is required. (Please initial)

_____I hereby **Grant Permission** for nonprescription medication (such as Tylenol, throat lozenges, cough syrup) to be given to my child, if deemed advisable. I understand that Aspirin will not be given to my son/daughter. (Please initial)

### Medical Conditions Information

(Diocesan personnel will take reasonable care to see that the following information will be held in confidence.)
My son/daughter has had an episode of the following or has been diagnosed: ☐Siezures Asthma ☐ Diabetic
Allergic reactions to the following (foods, dyes, latex etc.) _____
Has had a medical surgery within the last six months? Yes No Still under doctor's care? Yes No
Has a medically prescribed diet? _____
The following physical limitations? _____
Immunizations current and up to date: Yes No Date of last tetanus/diphtheria immunization _____
You should also be aware of these special medical conditions of my child: _____
_____

### Insurance Information

(Please attach a copy of the Insurance Card, front and back, with this form)

Insurance Carrier: _____

Name of Insured: _____

Insurance Policy Number: _____

Father's Name:_____ Day Phone: _____
Mother's Name:_____ Day Phone: _____

____**No, I do not carry medical insurance at this time.**

In the event it comes to the attention of the chaperones associated with the activity that my child becomes ill with repeated symptoms such as headache, vomiting, sore throat, fever, diarrhea, I want to be called immediately.
I fully understand the foregoing statements and sign this Parental/Guardian Medical Consent Waiver knowingly, freely, and willingly.

_____ _____
**Signature (Parent/Guardian)** **Date**

_____ _____
**Signature (Participant 18 years of age or older must sign own consent)** **Date**