This form is to be used for all young people through age 18.

FORM A

OUR LADY OF LOURDES CATHOLIC CHURCH
DIOCESE OF VICTORIA IN TEXAS
PERMISSION FORM/MEDICAL RELEASE

NAME_____ Gender _____Grade_____
Address_____ City _____
St/Zip_____ Phone (____) _____
Age _____ Birthdate_____ Parish_____

PARENT/LEGAL GUARDIAN'S NAME _____
Address (if different than above) _____
Phone (____) _____Cell (____) _____Wk (_____) _____

I request and give my consent for my son/daughter, _____ to participate in all church sponsored activities from **August 1, 2017** through **August 1, 2018**, sponsored by Our Lady of Lourdes Catholic Church and/or by the Diocese of Victoria. I understand that my son/daughter will be under the supervision of diocesan and/or parish personnel. As parent or legal guardian I agree to defend, indemnify and hold harmless the Diocese of Victoria and Our Lady of Lourdes Catholic Church, its clergy, officers, agents, employees and volunteers from any claims, costs or expenses for property damages, personal injuries or other damages arising out of my son/daughter's participation in the above mentioned activity or during the transportation to and from the event. I grant permission for non-prescriptive medication (e.g. tylenol, throat lozenges, cough syrup, pepto-bismol, etc.) and routine nonsurgical medical care to be given to my son/daughter if deemed advisable by the supervising diocesan personnel. In case of an emergency, I also grant permission to transport my child to the nearest hospital for emergency medical or surgical treatment and for an authorized adult sponsor to sign for treatment if I cannot be located. I hereby give permission for my son/daughter to be photographed or video taped. I realize that the photo maybe published in the newspaper, a magazine, or other publication. The video may be used for educational purposes or informational purposes regarding programs or curriculum.

_____ _____
Date Parent's Signature

Family Physician_____Phone (_____)_____
Address_____City/State/Zip_____
My son/daughter is allergic to:_____
My son/daughter takes the following medication (name, dosage):_____
This medication is for:_____ Medication that my son/daughter is allergic to:_____Last immunization/booster for Diphtheria/Tetanus:_____
Any specific medical problems:_____Any physical limitations:_____
In an emergency, if unable to reach parent/guardian, please contact:
Name_____Work Phone (_____)_____ Home Phone (____)_____
Name_____Work Phone (_____)_____ Home Phone (____)_____
Name of Insurance Company_____ Phone (____)_____
Address_____
City/St/Zip_____
Name of Insured_____Policy #_____
Group or Plan #_____