OUR LADY OF LOURDES

DIOCESE OF VICTORIA IN TEXAS

PERMISSION FORM/MEDICAL RELEASE

NAME_____ Gender: □ M or □ F Age _____

Address_____ City _____

St/Zip_____ Phone (____)_____

Birthdate_____Parish/City_____

I would like to participate in activities, sponsored by Our Lady of Lourdes of the Diocese of Victoria in Texas from August 1, 2018 through August 31, 2019. I agree to defend, indemnify and hold harmless the Diocese of Victoria, 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 participation in the above mentioned activity.

In case of an emergency, I grant permission and authorization for a designated adult representative of Our Lady of Lourdes of the Diocese of Victoria to sign for treatment by a local physician and/or hospital selected by Our Lady of Lourdes of the Diocese of Victoria in Texas. I hereby give permission to be photographed or videoed. 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_____ Signature_____

Family Physician_____ Phone (_____)_____

Address_____ City/Zip_____

1. Are you allergic to any type of medication? If so, please indicate: _____

Describe reaction? _____

2. Are you presently taking any prescription medication over an extended period of time? _____

Name of medication: _____ What is it for? _____

3. Do you have any allergies? _____ If so, what are they? _____

Last immunization/booster for Diphtheria/Tetanus:_____

Name of Insurance Company_____ Phone (____) _____

Address_____City/St/Zip_____

Name of Insured_____ Policy or Group Plan #_____

_____ I do not have insurance.

In an emergency, please contact:

Name _____Work Phone (_____) _____ Home Phone (____) _____

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All blanks must be filled out - if it does not apply, please indicate with a line (------) or by writing N/A.

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