St. John Catholic Church
Updated Liability Release, Permission & Health Form 2016-2017
Youth Ministry

Youth Name: ___________________________________ Home Phone: _______________________
Circle one: (Male / Female)

Parent Name: ____________________________________ Work Phone: _______________________

E-Mail Address: ____

Other Numbers where Parent/Guardian can be reached: ____

Address: ____
City/State/Zip: ______________________________

Date of Birth: _______________________________

In consideration of the wholesome recreational and learning experiences 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 the youth of ST. JOHN CATHOLIC CHURCH, WESTMINSTER, MARYLAND in the activities that I/we are notified about and agree to.

I by so permitting my teen to participate, I/we expect reasonable supervision of him/her. It is thus agreed that I/we will RELEASE AND HOLD HARMLESS AND INDEMNIFY St. John Roman Catholic Church, the Division of Youth & Young Adult Ministry of the Archdiocese of Baltimore, the Roman Catholic Bishop of Baltimore and his successors, a Corporate Sole, and all their agents, servants and employees from any liability, claims, demands and causes of action arising out of or relating to any loss, damage or injury sustained in connection with or arising out of my son/daughter's participation in the Program. I will also inform the church of any changes to my medical insurance information.

I hereby grant permission for appropriate photographs of my child to be taken for the purpose of inclusion in slide-shows, newsletters, and the St. John Parish website. Your child will not be identified without your written consent. Parents who do not wish their child to be photographed should so notify St. John in writing.

I hereby grant permission to any staff person to obtain medical care from a licensed physician, hospital, or medical clinic for my son/daughter in the event that I cannot be reached. (Check one of the following:)

_____ I am covered by hospitalization and medical insurance under policy#:__________________________
Issued by:____.

_____ I do not have medical coverage and assume responsibility for the cost of hospitalization and medical care for my son/daughter.

I hereby grant permission to any staff person to provide the following over-the-counter drug (or generic substitute) to my son/daughter if requested by my son/daughter (Check all that apply)

___Tylenol ___Benadryl ___Advil ___Sudafed ___Midol ___Kaopectate ___Neosporin

ADD here any other medical information concerning medication, allergies, illness, etc:
____

____

ADD here any dietary restrictions:
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________________ ______________________________________
Date Parent/Guardian Signature

________________ ______________________________________
Date Parent/Guardian Signature