

# AUTHORIZATION FOR ACTIVITIES AND EMERGENCY TREATMENT FOR DIOCESAN ACTIVITIES

I give permission for \_\_\_\_\_ Age \_\_\_\_\_ Gender \_\_\_\_\_  
to participate in \_\_\_\_\_ on (date) \_\_\_\_\_

Signature of parent(s)/guardian(s) of above named child \_\_\_\_\_ Date \_\_\_\_\_

Medical Information (If more space is needed, please write on the back)

List any medications which your daughter/son/guardian has in his/her possession at this event:

Can your young person take responsibility for his/her medication or would you prefer that it be given with staff supervision (in which case, supply all necessary instruction from your physician).

Please list any allergies or other physical or health conditions of which we should be aware:

Are there any first aid ministrations such as aspirin or antibiotic ointment we should avoid using?

In case of medical emergency, I/we understand that every effort will be made to contact the parent or guardian. In event I/we cannot be reached, I/we hereby give permission to the dentist or physician designated by the staff to hospitalize, secure proper treatment and/or to order an injection, anesthesia, or necessary surgery. I/We give our permission to engage in all activities as noted below or on the back of this form, including, but not limited to use of the Ropes Course/Adventure activities provided all safety measures and standards are followed. I also give permission for photographs or video of my child to be used by the diocese for promotional or other purposes. I hereby indemnify and agree to hold harmless the Diocese of Southern Virginia, its members, representatives, officers, agents, employees, directors, and each of them, for any and all past, present, or future loss to property, and/or bodily injury resulting from any activities engaged. The completed forms may be photocopied and used as an original.

Date \_\_\_\_\_  
Signature Of parent(s)/guardian(s) of above name child \_\_\_\_\_

Printed Name \_\_\_\_\_

Address \_\_\_\_\_

Tel: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell/Pager \_\_\_\_\_

Medical Insurance Company: \_\_\_\_\_

Medical Insurance ID number \_\_\_\_\_ Group# \_\_\_\_\_

Other person to contact (as alternative means of reaching you in case of emergency)

Name: \_\_\_\_\_ Relationship to participant: \_\_\_\_\_

Address: \_\_\_\_\_

Tel: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell/Pager \_\_\_\_\_