

Diocese of Corpus Christi Office of Evangelization and Catechesis

St. Thomas More, Corpus Christi, TX

PARENTAL/GUARDIAN CONSENT, LIABILITY

I, _____, grant St. Thomas More and its Ministries:
including, but not limited to, Religious Education, LifeTeen, Confirmation & Edge Programs permission for
my child/children _____, to

(parent/guardian)
(child's/children's name, please list all)
participate in all activities/events that may held from August 20 ____ to July 20 ____

I agree on behalf of myself, my child's other parent, if known or living
my child named herein, or our heirs,

(name of parent(s) not signing this form)
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.

SPECIAL NEEDS (EDUCATIONAL) INFORMATION

Information listed below remains confidential and will only be used for purposes related to assisting the Catechist. If more
space is needed, please attach a separate sheet to this form. It is recommended that parents of children that have special
needs also be provided a one on one meeting with the parish catechetical leader to discuss learning needs.

List any educational or behavioral needs:
Child 1: Child 2: Child 3:

PICK-UP AUTHORIZATION

Please list below those who are authorized by you to pick-up your child from class:
1. Name: 2. Name:
Relationship to child: Relationship to child:
Phone: Phone:

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)

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.

I grant permission for pictures/video I DO NOT grant permission for pictures/video

Signature (Parent/Guardian) Date

Signature (Participant 18 years of age or older must signown consent) Date

MEDICAL CONSENT

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: _____

Family Doctor: _____

Phone: _____

MEDICAL CONDITIONS INFORMATION (Diocesan personnel will take responsible care to see that the following information will be held in confidence.) If more than 3 children, please use an additional form

	Child # 1	Child # 2	Child # 3
Full Name (as on Birth Certificate)			
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: Dosage: Administer:	Medication: Dosage: Administer:	Medication: Dosage: Administer:
I hereby Do Not Grant Permission for medication of any type, whether prescription or nonprescription may be administered to my child unless the situation is life threatening and emergency treatment is required. (Please initial)			
OR	<i>Please Initial</i>	<i>Please Initial</i>	<i>Please Initial</i>
I hereby Grant Permission for nonprescription medication (such as Tylenol/Advil, throat lozenges, cough syrup, Imodium) to be given to my child, if deemed advisable. I understand that Aspirin will not be given to my son/daughter. (Please initial)			
	<i>Please Initial</i>	<i>Please Initial</i>	<i>Please Initial</i>
My child has had an episode or been diagnosed with:	<input type="checkbox"/> Seizures <input type="checkbox"/> Diabetic <input type="checkbox"/> Asthma <input type="checkbox"/> Other-Explain	<input type="checkbox"/> Seizures <input type="checkbox"/> Diabetic <input type="checkbox"/> Asthma <input type="checkbox"/> Other-Explain	<input type="checkbox"/> Seizures <input type="checkbox"/> Diabetic <input type="checkbox"/> Asthma <input type="checkbox"/> Other-Explain
My child has had allergic reactions to the following foods, dyes, latex, medication, etc:			
	<i>Please list, if none put NA</i>	<i>Please list, if none put NA</i>	<i>Please list, if none put NA</i>
Does your child need to carry an EPI Pen? And if so, can child administer to himself/herself?			
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
My child as had a medical surgery within the last six months			
	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain
My child has a medically prescribed diet			
	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain
My child has the following physical limitations			
	<i>Please list, if none put NA</i>	<i>Please list, if none put NA</i>	<i>Please list, if none put NA</i>
My child's immunizations are current	<input type="checkbox"/> Yes <input type="checkbox"/> No Date of last tetanus/diphtheria	<input type="checkbox"/> Yes <input type="checkbox"/> No Date of last tetanus/diphtheria	<input type="checkbox"/> Yes <input type="checkbox"/> No Date of last tetanus/diphtheria
You should also be aware of these special medical conditions	<i>Please list, if none put NA</i>	<i>Please list, if none put NA</i>	<i>Please list, if none put NA</i>

INSURANCE INFORMATION

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

Insurance Carrier: _____

Father's Name: _____

Insurance Policy Number: _____

Father's Day Phone: _____

Name of Insured: _____

Mother's Name: _____

Day Phone: _____

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. If this will be a long distance call, I want to be called collect (with phone charges reversed to myself). 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