

Risen Savior Youth Ministry – 2020-2021
UNIVERSAL CONSENT FORM, MEDICAL INFO, & PERMISSION SLIP
952-698-1727

Name: _____ Age: _____ Birth date: ___/___/___ Gender: Male
 Female

Phone: _____ Cell Phone: _____

Email: _____ School: _____ Grade: ___ Address: _____

_____ City _____ Zip _____

Mother's name: _____ Mother's Email: _____

Mother's Phone (Daytime): _____ (Cell) _____

Father's name: _____ Father's Email: _____

Father's Phone (Daytime): _____ (Cell) _____

Doctor's Name: _____ Phone: _____

Address: _____ City _____ Zip _____

Health Insurance Company: _____ Policy #: _____

Names and Phone numbers of two relatives and/or friends to contact if parents cannot be reached:

1) Name & Relationship: _____ Phone: _____

2) Name & Relationship: _____ Phone: _____

Specific Medical Information: Reasonable care will be taken to keep the following information confidential.

Will you be bringing and/or using any medication during these events? Yes No

If YES, please explain: _____

If YES My child is taking medication at present & will bring all medications necessary & medications will be well-labeled. Names of medications & concise directions (including dosage & frequency) for seeing that my child takes such medications, & the medications will be given to the Director of Youth Ministry for distribution:

Signature: _____ **Date:** _____

Allergies (medications, foods, plants, insects, etc.): _____

Immunizations: Date of last tetanus/diphtheria immunization: _____

Does child have a medically prescribed diet? _____

Any physical limitations? _____

History of chronic homesickness, emotional reactions to new situations, sleepwalking, bedwetting, fainting? _____

Has child recently been exposed to contagious disease or conditions, such as mumps, measles, chicken pox, etc.? If so, list date and disease or condition: _____

You should be aware of these special medical conditions of my child: _____

Medical Matters: I hereby warrant that to the best of my knowledge, my child is in good health, and I assume all responsibility for the health of my child.

Medical Treatment: In the event it comes to the attention of the parish, its officers, directors and agents, and the Archdiocese of St. Paul and Minneapolis, chaperones, or representatives associated with the activity, that my child becomes ill with symptoms such as headache, vomiting, sore throat, fever, diarrhea, I want to be called.

Signature: _____ **Date:** _____

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I, _____ grant permission for my child, _____
Parent or guardian's name Child's name

to take part in the 2020-2021 YOUTH MINISTRY PROGRAM sponsored by Church of the Risen Savior (RS). This program takes place under the guidance and direction of parish employees and/or volunteers from RS. As parent and/or legal guardian, I remain legally responsible for any personal actions taken by the above named minor (“participant”). In consideration of the opportunity for my child to participate and fully recognizing that such an undertaking involves an element of risk, I on behalf of myself, my child named herein, or our heirs, successors, and assigns, assume all risks and hazards incidental to such participation and so hereby release, absolve, indemnify, and agree to hold harmless and defend Church of the Risen Savior, its officers, directors, employees, agents, chaperones, sponsors, organizers, leaders, and the persons transporting our child and the ArchDiocese of St. Paul and Minneapolis, its employees and agents, chaperones, or representatives associated with the event, from any claim arising from or in connection with my child attending the program events or in connection with any illness or injury (including death) or cost of medical treatment in connection therewith, and I agree to compensate the parish, its officers, directors and agents, and the Archdiocese of St. Paul and Minneapolis, its employees and agents and chaperones, or representative associated with the event for reasonable attorney’s fees and expenses which may incur in any action brought against them as a result of such injury or damage, unless such claim arises from the negligence of the parish/diocese. I authorize RS to use photos or videos taken of my child during events for promotional purposes only. At no time will events photos or videos be used by unrelated organizations. I, the undersigned, have read this release and understand all its terms and execute it voluntarily and with full knowledge of its significance. In the event of an emergency and we cannot be contacted, I hereby give permission to transport my child to a hospital for emergency medical or surgical treatment.

I UNDERSTAND THAT IF THERE ARE ANY CHANGES DURING THE 2020-2021 PROGRAM YEAR IT IS THE PARENTS OR YOUTHS RESPONSIBILITY TO UPDATE THIS INFORMATION WITH THE YOUTH MINISTRY.

Signature: _____ **Date:** _____

CODE OF CONDUCT

The following are a few rules all participants are expected to follow while participating and representing Church of the Risen Savior (RS) during the 2020-2021 Program Year.

Please read and sign. I, _____, will:

(Printed Name of Youth Participant)

- Treat all other persons with respect and not cause any intentional harm (physically, emotionally, or spiritually) to any person in any way.
- Respect the property of others, including all program facilities and property.
- Follow all appropriate instructions of all personnel aiding in this event, including, but not limited to, chaperones, support staff, transportation personnel and administration.
- Be on time for all check-in and departure times.
- Not have in my possession any tobacco, alcohol or any controlled illegal substance.
- I agree that if any of these terms are violated, Church of the Risen Savior can send the participant home at the participant/guardian’s expense.

(Youth Participant Signature) **(Date)**

(Parent/Guardian Signature) **(Date)**

Please read carefully and select one of the following options:

No medication of any type, whether prescription or non-prescription, may be administered to my child unless the situation is life-threatening and emergency treatment is required.

Signature: _____ _____

OR **(Date)**

I hereby grant permission for non-prescription medication (i.e. non-aspirin products such as acetaminophen or ibuprofen, throat lozenges, cough syrup) to be given to my child, if deemed appropriate.

Signature: _____ _____

(Date)