WAIVER, RELEASE, AND MEDICAL INFORMATION
CATHOLIC DIOCESE OF EVANSVILLE

Youth's Name _____ Age _____ Grade _____
ST. CELESTINE CHURCH – ST. RAPHAEL CHURCH

Event:	Abortion Mill in Louisville to prayerfully protest abortion. We are spending the night at Mount St. Francis Retreat Center in New Albany.
Cost:	$10 to secure your spot for the trip (money will pay for gas and snacks) (It's also a day of fasting…big "feast" after midnight on snacks! Traci will supply.)
What to bring:	Pillow/blanket/sleeping bag, warm clothes, toiletries, games, snacks if you wish
Date(s) of Event	Friday, April 18 **LEAVING Celestine from parish center at 4:45 pm, return the next day around 11 am** Contact Person: Traci Catt 631-3330 (cell)

Permission slips due by April 14 so enough transportation is available.

I/We, the parents(s) of the above-named youth, hereby give my/our approval for his/her participation in the above event. I/We assume all risks and hazards incidental to the conduct of the activities and transportation to and from the event. I/We do further hereby waive, release, absolve, indemnify and hold harmless the Bishop of the Catholic Diocese of Evansville,
St. Celestine Parish/St. Raphael, Rev. Eugene Schmitt, Pastor
and any of their respective affiliates, successors, agents, employees, members, and representatives, adult sponsors, and other volunteers involved in the activities and transportation associated with the event from any and all claims, including claims of personal injury to my/our youth or property damage, under any theory of law (including negligence, but not reckless or intentional conduct) in any way resulting from or arising in connection with the activities and/or transportation to and from the event.

Father's Signature**X** _____Date _____
Mother's Signature**X** _____Date _____
{Guardian's Signature**X** _____Date _____

EMERGENCY INFORMATION
Family Name _____
Address_____City _____ST_____ Zip _____
Phone during event _____
Contact Father at _____Phone _____
Contact Mother at _____Phone _____
Contact Guardian at _____Phone _____
If Guardian cannot be reached, call:
Name _____Phone _____
Name _____Phone _____
Family Physician _____Phone _____
Hospital Preference _____
Parents living together? Yes No With whom does the child live? _____
-Is there anyone who by court order or decree is designated as the primary or sole custodial parent? _____
-NAME anyone who has been restrained from picking up the child? _____
I understand it is my responsibility to keep the youth minister informed about such matters and to provide copies of relevant court orders and decrees to officials.

MEDICAL INFORMATION:
List any chronic or existing disease or medical problems (e.g. diabetes, epilepsy)

List any instructions for care of the above if it becomes necessary at school:

List any medications your child is taking on a regular basis: (SEE BELOW)

In case of accident or serious illness I request the contact person to contact me. If I cannot be reached, I hereby authorize parish staff to make whatever arrangements the circumstances allow. It is understood and agreed that neither the Parish, Youth Minister, nor the Catholic Diocese of Evansville is the insuror of my child's health and safety while he/she is at youth functions or engaged in supervised activities, including sports. I understand it to be my obligation to provide such insurance as I may desire to purchase to protect myself and my child against the costs of sickness or injury. If the above named child needs emergency medical treatment, and neither a parent nor the designated family physician can be contacted, consent is hereby granted for such emergency treatment as may be considered necessary in the opinion of the attending physician.

Father or Guardian's Signature **X** _____ Date _____

Mother or Guardian's Signature **X** _____ Date _____

AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATION BY AUTHORIZED PERSONNEL
I HEREBY AUTHORIZE PERSONNEL TO ADMINISTER MEDICATION AS INDICATED TO:

Name _____Grade_____ Youth Minster_____

Rx Number _____ Name of Medication_____

Directions:_____

Doctor _____Phone _____Pharmacy_____
Time medication is given at home:

Time medication is to be given at the event:

I UNDERSTAND THAT MY SIGNATURE RELIEVES THE PARISH PERSONNEL OF ANY AND ALL LIABILITY RELATED TO THE ADMINISTRATION OF THE PRESCRIBED MEDICATION.
Signature of Parent/Guardian **X** _____Date_____

- **Phone number where you may be reached during event:**
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