PARENT/GUARDIAN
PERMISSION SLIP/ MEDICAL AUTHORIZATION/ INDEMNITY AGREEMENT

SPONSOR OF ACTIVITY Church of the Incarnation
ACTIVITY Cardboard Box City 2018
DATE(S) OF ACTIVITY September 1 & 2, 2018
PLACE OF ACTIVITY Church of the Incarnation, Rio Rancho, NM

The undersigned as parent or legal guardian of _____, does hereby give permission for the above named individual to attend the described activity.

As a condition of attending the described activity, I do hereby release the Roman Catholic Archdiocese of Santa Fe and all its affiliated parishes, schools and organizations, as well as their officers, agents and employees, from any and all claims, demands, actions, or causes of action due to death, injury, or illness, in any way, arising from the above described activity, including, but not limited to transportation to and from the event.

I further agree that the financial responsibility for securing care, in case of injury resulting from participation in the program, is a matter between the participant and his/her health care provider, and that the Archdiocese of Santa Fe cannot pay health care providers for treatment of any injuries. It is further agreed, that the participant will assume all legal responsibility for their personal safety and actions while participating in the program and while traveling to and from the program activities.

I hereby authorize the Supervisor of the activity or his/her designee to act in my behalf to authorize such medical attention, surgery, or other health care services, as may be recommended in an emergency situation while participating in the activity. If the below named physician cannot be reached, I hereby authorize any licensed physician or medical center to treat my child.

I hereby authorize the supervisor of the activity or his/her designee to administer the following medication to my child according to the instructions described here:

Medication_____

Directions_____

If the medication is prescribed by a doctor, the prescription in its original container will be provided to the supervisor of the activity.

Name of Physician: _____Phone_____

Signature:(Parent/Guardian)_____Date:_____

Phone: (H)_____ (W)_____

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HEALTH FORM

Name_____ DOB _____

Street_____City _____ State _____ Zip_____

Is this participant in general good health and able to participate in all normal activities?
YES ____ NO ____ (If not, please submit a statement indicating limitations.)

Please give date of most recent physical examination. Date: _____

Family physician or clinic: _____Phone: _____

Street _____City _____ State _____ Zip_____

Immunization History

GIVE DATES PLEASE
DPT _____ DPT BOOSTER _____ TETANUS BOOSTER _____
POLIO SERIES _____ POLIO BOOSTER _____

Allergies (Please write yes or no next to each)
HAY FEVER _____ ASTHMA _____ SULFA _____ FAINTING _____
POISON IVY _____ CONVULSIONS _____ PENICILLIN _____ BEE STING _____
OTHER (Please specify) _____

If any of the above are yes, please submit a statement of how the child has been treated and with what medication. This and any other medication will be dispensed by the Director.
Operation or Serious Injury _____ Dates _____.

Please notify the Director if this child is exposed to any communicable disease during the three weeks prior to attendance.

In signing this application. I hereby certify that the above information is correct and give permission for my child to be transported in privately owned vehicles to and from public transportation or for approved out-of-institute activities; and for the release of medical records to an attending physician in case at illness.

In case of medical emergency, I understand that every effort will be made to contact parents or guardian of participants. In the Event that I cannot be reached, I hereby give permission to the physician selected by the Institute Director to hospitalize, secure property treatment for, and to order injection, anesthesia or surgery for my child, as named herein.

SIGNATURE OF PARENT / GUARDIAN _____ DATE _____

Telephone: _____ Alternate Phone Number _____

Family Health Insurance Co.: _____ Policy No. _____

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