

CAYOCA 2009 Online Registrant: Parental/Guardian Consent Form and Liability Waiver

Complete and send by **MAY 1, 2009** to:

Diocese of Sioux City, Youth & Young Adult Ministry, PO Box 3379, Sioux City, IA 51102

Participant's Name _____ Birth Date: _____

Home Address _____

Parent/Guardian's Name _____

Home Phone _____ Business Phone _____ Cell Phone _____

Registered for Camp: June 3 - 6 Grades 3-5 A June 11 - 14 Grades 3-5 C
 June 7 - 10 Grades 3-5 B June 15 - 18 Grades 6-8

Pictures of my child (or self) taken during the event may be used in print or electronic media for the purposes of publicity for future events, unless I indicate to the Diocesan Youth Ministry Director in writing to the contrary.

I, _____ grant permission for my child (or self), _____ to participate in this parish event that requires transportation to a location away from the parish/school site. This activity will take place under the guidance and direction of parish employees and/or volunteers from the Diocese of Sioux City. As parent and/or legal guardian, I remain legally responsible for any personal actions taken by the above named minor ("participant").

I agree on behalf of myself, my child named herein, or our heirs, successors, and assigns, to hold harmless and defend the Diocese of Sioux City, its officers, directors, employees, chaperones, representatives and agents associated with the event, from any claim arising from or in connection with my child (or self) attending the event 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 Diocese of Sioux City, 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.

Signature _____ *Date* _____

MEDICAL MATTERS: I hereby warrant that to the best of my knowledge, my child (or self) is in good health, and I assume all responsibility for the health of my child (or self). (Of the following statements pertaining to medical matters, sign only those that are applicable.)

Emergency Medical Treatment: In the event of an emergency, I hereby give permission to transport my child (or self) 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, if you are unable to reach me at the above numbers, contact:

Name & Relationship _____ Phone _____

Family Doctor _____ Phone _____

Family Health Plan Carrier _____ Policy # _____

Signature _____ *Date* _____

Other Medical Treatment: In the event it comes to the attention of the parish, its officers, directors and agents, and the Diocese of Sioux City, chaperones, or representatives associated with the activity that my child (or self) becomes ill with symptoms such as headache, vomiting, sore throat, fever, diarrhea, I want to be called collect (with phone charges reversed to myself).

Signature _____ *Date* _____

Medications: My child (or self) is taking medication at present. My child(or self) will bring all such medications necessary, and such medications will be well-labeled. Names of medications and concise directions for seeing that the child takes such medications, including dosage and frequency of dosage, are as follows: _____

Signature _____ *Date* _____

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

Signature _____ *Date* _____

OR

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

Signature _____ *Date* _____

Specific Medical Information: The parish will take reasonable care to see that the following information will be held in confidence.

Allergic reactions (medications, foods, plants, insects, etc.) _____

Date of last tetanus/diphtheria immunization: _____

Does child (or self) have a medically prescribed diet? _____

Any physical limitations? _____

Is the child subject to chronic homesickness, emotional reactions to new situations, sleepwalking, bedwetting, fainting? _____

You should be aware of these special medical conditions of my child (or self): _____