Youth Permission Slip

*(This permission slip is to be filled out, **IN ITS ENTIRETY**, for **EACH ACTIVITY** in which any youth is involved).*

Name of Youth: _____ DOB: _____ Weight: ____ Height: ___
Street Address/City/State/Zip: _____
Grade Level, Subject, and Teacher's Name: _____

Name and Location of Activity: _____
Date: _____ Time: _____

Special Information:

_____ (Initial) Yes, I can drive. Number of backseat seatbelts available for students: _____.

I, THE PARENT (GUARDIAN) OF THE ABOVE NAMED CHILD, HEREBY, GIVE MY PERMISSION FOR HIS/HER PARTICIPATION IN THE YOUTH ACTIVITY NAMED ABOVE. I AGREE TO DIRECT MY CHILD TO COOPERATE AND CONFORM TO DIRECTIONS AND INSTRUCTIONS OF PARISH, SCHOOL AND DIOCESAN PERSONNEL RESPONSIBLE FOR THIS ACTIVITY.

I agree that in the event my child is injured as a result of his/her participation in the above named activity, including transportation to and from this activity, whether or not caused by the negligence (active or passive) of the parish/school or diocesan youth activity program, or any of its agents or employees, recourse for the payment of any resulting hospital, medical, or related costs will first be paid by parent or guardian insurance or any available benefit plan of parent or guardian.

I am not aware of any medical condition of my child, which would render it inappropriate for him/her to participate in any activity.

I, hereby, give permission to the medical personnel selected by the youth activity supervisory personnel present should parent/guardian not be available for permission or consultation, to render medical treatment deemed necessary and appropriate by the physician, R.N., or dentist.

I understand that during the activity my child will be transported to and from the activity site via a personal vehicle and/or van or chartered bus.

Parent/Guardian Signature: _____ Date: _____

IT IS THE PARENTS RESPONSIBILITY TO UPDATE THE MEDICAL HISTORY FORM ON FILE IN ST. JOSEPH'S SCHOOL OFFICE.

MEDICAL HISTORY FOR ANY HOSPITAL OR PRACTITIONER

Please complete the following in its entirety and return.

YOUTH'S NAME: _____

YOUTH'S AGE: _____

YOUTH'S GRADE LEVEL: _____

PARENT/GUARDIAN INFORMATION

Mother's Name: _____
Mother's Phone: _____ (Home) _____ (Work) _____ (Cell)

Father's Name: _____
Father's Phone: _____ (Home) _____ (Work) _____ (Cell)

Guardian's Name: _____
Guardian's Phone: _____ (Home) _____ (Work) _____ (Cell)

Emergency Contact: _____
Relationship: _____
Emergency Phone: _____ (Home) _____ (Work) _____ (Cell)

YOUTH INFORMATION

Allergies: _____
Medication being taken: _____
Date of last tetanus shot: _____
Physical Impairments: _____
Other health issues the Physician should be aware of: _____

Family Physician: _____
Address: _____
Phone: _____

Medical Insurance Co.: _____
Policy Number: _____
Subscriber's Name: _____