FORM A

DIOCESE OF VICTORIA IN TEXAS
PERMISSION FORM/MEDICAL RELEASE

NAME_____ Gender _____Grade_____

Address_____ City _____

St/Zip_____ Phone (____) _____

Age _____ Birthdate_____ Parish_____

PARENT/LEGAL GUARDIAN'S NAME _____

Address (if different than above) _____

Phone (____) _____Cell (____) _____Wk (_____) _____

I request and give my consent for my son/daughter, _____ to participant in D-Week, June 24-27, 2013 sponsored by NET Ministries and the Diocese of Victoria that will be held at the Spiritual Renewal Center. I understand that my son/daughter will be under the supervision of diocesan and/or NET Ministries personnel. As parent or legal guardian, I agree to defend, indemnify and hold harmless the Diocese of Victoria, its clergy, officers, agents, employees and volunteers from any claims, costs or expenses for property damages, personal injuries or other damages arising out of my son/daughter's participation in the above mentioned activity or during the transportation to and from the event. I grant permission for non-prescriptive medication (e.g. tylenol, throat lozenges, cough syrup, pepto-bismol, etc.) and routine nonsurgical medical care to be given to my son/daughter if deemed advisable by the supervising diocesan personnel. In case of an emergency, I also grant permission to transport my child to the nearest hospital for emergency medical or surgical treatment and for an authorized adult sponsor to sign for treatment if I cannot be located. I hereby give permission for my son/daughter to be photographed or video taped. I realize that the photo maybe published in the newspaper, a magazine, or other publication. The video may be used for educational purposes or informational purposes regarding programs or curriculum.

_____ _____

Date Parent's Signature

Family Physician_____Phone (_____)_____

Address_____City/State/Zip_____

My son/daughter is allergic to:_____

My son/daughter takes the following medication (name, dosage):_____

This medication is for:_____ Medication that my son/daughter is allergic

to:_____Last immunization/booster for Diphtheria/Tetanus:_____

Any specific medical problems:_____Any physical limitations:_____

In an emergency, if unable to reach parent/guardian, please contact:

Name_____Work Phone (_____)_____ Home Phone (____)_____

Name_____Work Phone (_____)_____ Home Phone (____)_____

Name of Insurance Company_____ Phone (____)_____

Address_____

City/St/Zip_____

Name of Insured_____Policy #_____

Group or Plan #_____