**WAIVER, AND MEDICAL INFORMATION FOR ST. JOHN THE BAPTIST PARISH**
**AND THE CATHOLIC DIOCESE OF EVANSVILLE,**

**(Please print neatly)**

Youth's Name(s)_____________________________________________Age(s)______Grade(s)______
_____________________________________________ ___________
_____________

Parent(s) or Guardian(s) Name(s):
__________________________________________________________
Address____________________________________City____________________Zip____________
Phone____________________________________ Email____________________________________
School & Church ________________________________________City________________________

I/We, the parents(s) of the above-named youth, hereby give my/our approval for his/her/their participation in the St. John Religious Education Programs, from September 1, 2011 thru May 31, 2012**.** 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. JOHN THE BAPTIST PARISH** Newburgh, IN, **REV. JOSEPH ZILIAK,** 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.

I/We, the parents(s) of the above-named youth, hereby give my/our permission for him/her/them to be photographed or videotaped during the Religious Education Programs from September 1, 2011 thru May 31, 2012**.** I/We realize that the photos may be published or posted in publications such as, but not limited to: the parish newsletter, bulletin boards, parish videos, newspapers, or other publications. Such photos or videos may be used for educational, informational, or promotional purposes regarding the programs or curriculum at St. John the Baptist Parish.

**EMERGENCY INFORMATION**

Address________________________________City ____________________St______ Zip ____________
Home Phone ________________________Father's Cell _______________Mother's Cell _______________
Father's name & place to contact: ____________________________________ Phone ___________________
Mother's name & place to contact: ___________________________________ Phone ___________________
Guardian's name & place to contact: __________________________________Phone ___________________
If Parents or Guardian cannot be reached, call:
Name ________________________Relationship ______________________Phone ___________________
Name ________________________Relationship ______________________Phone ___________________
Family Physician ____________________________________________________Phone ___________________
Hospital Preference ________________________________________________________________________
Parents living together? Yes No With whom does the child live? _______________________________

NAME anyone who by court order or decree is designated as the primary or sole custodial parent?
_____________________________________________________________________________

NAME anyone who by court order or decree has been restrained from picking up the child?
_____________________________________________________________________________

**List any chronic or existing disease or medical problems we need to be aware of:**

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

I/We understand it is my/our responsibility to keep the DRE, CRE, or Youth Minister/Coordinator informed about all such matters mentioned above and to provide copies of relevant court orders and decrees to officials. I/We herby understand, acknowledge, and give my permission to all that is written in this document:
Father's Signature X ____________________________________________Date __________________
Mother's Signature X ____________________________________________Date__________________
Guardian's Signature X____________________________________________Date__________________

**IF REQUIRED, SEE REVERSE FOR AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATION BY AUTHORIZED PERSONNEL**

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**AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATION BY AUTHORIZED PERSONNEL**

I HEREBY AUTHORIZE PERSONNEL TO ADMINISTER MEDICATION AS INDICATED TO:

Name_____________________________________________ Name of Medication:_____________________________

Rx Number:_________________________Directions:_____________________________________________________

Doctor:____________________________________________________________Phone:_________________________

Pharmacy:__________________________________________________________Phone:_________________________

Time(s) medication is given at home:_________________________________________________________________

.___________________________________________________________________________________________________

I UNDERSTAND THAT MY SIGNATURE RELIEVES THE DRE, CRE, AND/OR YOUTH MINISTER OF ANY AND ALL LIABILITY RELATED TO THE ADMINISTRATION OF THE PRESCRIBED MEDICATION.

Guardian’s Signature X__________________________________________________Date_______________________

Phone during the event:__________________________________________________