

**ST. ROSE OF LIMA YOUTH MINISTRY ACTIVITY  
PARENTAL PERMISSION & RELEASE FORM**

*Please complete and return this form by: \_\_\_\_\_*

My child, \_\_\_\_\_, has my permission to participate with the parish youth ministry group to:

**(Event/Activity)** \_\_\_\_\_

**(Place)** \_\_\_\_\_

**(Date)** \_\_\_\_\_

**(Arrival time)** \_\_\_\_\_ **(Pick up time)** \_\_\_\_\_ **(Cost)** \_\_\_\_\_

**(Chaperone name & phone #)** \_\_\_\_\_

**(Transportation)** \_\_\_\_\_

**(Activity details)** \_\_\_\_\_

I hereby agree to indemnify and hold harmless St. Rose of Lima Catholic Church, the Archdiocese of Philadelphia and its officers, employees, and volunteer staff from any liability. I accept responsibility for any medical expenses as a result of any such injury sustained.

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Parent or Guardian Signature                      Phone                      Date

**MEDICAL RELEASE**

To Whom It May Concern:

As a parent and/or guardian, I do herewith authorize the treatment by a qualified and licensed medical doctor for in the event of a medical emergency which, in the opinion of the attending physician, may endanger his or her life, cause disfigurement, physical impairment or undue discomfort if delayed. This authority is granted only after a reasonable effort has been made to reach me.

This release is intended for \_\_\_\_\_ (date). This release form is completed and signed of my own free will with the sole purpose of authorizing medical treatment under emergency circumstances in my absence.

*[Please notify the rectory whenever there is a change in medical/insurance information on file in the office.]*

\_\_\_\_\_  
Name of Parent

\_\_\_\_\_  
Date

\*All guests must complete a medical/insurance form.

**ST. ROSE OF LIMA YOUTH MINISTRY PROGRAM  
MEDICAL INFORMATION & LIABILITY RELEASE**

**Please print and complete all areas.**

Name \_\_\_\_\_ Birth Date \_\_\_\_\_  
*First Initial Last*

Address \_\_\_\_\_  
*Street City State Zip*

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

**EMERGENCY TELEPHONE NUMBERS:**

Phone numbers where our youth ministry leader can reach a parent or an emergency contact for the child named above during scheduled events.

Parent/Legal Guardian: Cell \_\_\_\_\_ Work \_\_\_\_\_

Emergency Contact: Name \_\_\_\_\_ Phone \_\_\_\_\_

**MEDICAL INSURANCE CARRIER:**

Parent/Guardian's Insurance Group Name \_\_\_\_\_

Insurance Group Number \_\_\_\_\_

**MEDICAL INFORMATION:**

- Family physician's Name \_\_\_\_\_ Phone \_\_\_\_\_
- Date of last tetanus shot: \_\_\_\_\_
- Allergies, conditions, dietary restriction, special needs, medical concerns of which we should be aware:  
Food \_\_\_\_\_ Drug \_\_\_\_\_  
Animal \_\_\_\_\_ Other \_\_\_\_\_
- Limitations of which we should be aware: \_\_\_\_\_
- My child requires the following medicine: \_\_\_\_\_ Frequency \_\_\_\_\_
- My child has permission to be given Tylenol or Ibuprofen if they request it.  
Yes No

In case of Medical Emergency I understand that, in the event medical treatment is required, every effort will be made to contact me or the emergency contact person. However, if I cannot be reached, I give permission to the staff to secure the services of a licensed physician to provide the care necessary, including hospitalization, anesthesia, injection, or surgery for my child's well-being. I hereby agree to indemnify and hold harmless St. Rose of Lima Catholic Church, the Archdiocese of Philadelphia and its officers, employees, and volunteer staff from any liability.

\_\_\_\_\_  
Signature of Parent or Legal Guardian Date \_\_\_\_\_

**THIS FORM MUST BE RETURNED FOR YOUTH MINISTRY REGISTRATION TO BE COMPLETED.**