

PLEASE NOTE: The Authorization for Emergency Medical Treatment form must be completed and **notarized** before any off campus activities can be participated in.

Name \_\_\_\_\_ Nickname \_\_\_\_\_ Sex: \_\_\_\_\_  
(Name Preferred on Nametag)

Home Phone: \_\_\_\_\_ Parents Email \_\_\_\_\_

Mother's Cell: \_\_\_\_\_ Father's Cell \_\_\_\_\_ Student's Cell \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Student's Email \_\_\_\_\_ Student's Facebook \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Grade in Fall of 2010 (Please circle): 9<sup>th</sup> 10<sup>th</sup> 11<sup>th</sup> 12<sup>th</sup> School: \_\_\_\_\_

Has student been confirmed? Y/N

\*\*\*\*\*

Favorite hobbies/interests outside of sports: \_\_\_\_\_

\*\*\*\*\*

**Catholic Diocese of Peoria  
PERMISSION FORM**

I, \_\_\_\_\_, grant permission for my child, \_\_\_\_\_, to participate in  
(Parent or guardian's name) (child's name)

the **Holy Family Parish Youth Ministry**.(ACT) Youth Ministry activities will take place under the guidance and direction of **Holy Family Parish** employees and/or volunteers.

I understand the risks such activities present to my child, including, but not limited to serious personal injury or death. Any questions I have concerning these activities have been answered.

As parent and/or legal guardian, I remain legally responsible for any personal actions taken by the above named minor (participant).

In consideration for my child being allowed to participate in this activity, I hereby **RELEASE AND AGREE TO INDEMNIFY AND HOLD HARMLESS** Holy Family Parish, the Catholic Diocese of Peoria, and their employees and agents, and the volunteers assisting Holy Family Parish, from any and all liability for injuries, damages, medical expenses, or any other loss to my child or family or me (including attorneys' fees) arising from or related to my child's participation in Youth Ministry activities.

\_\_\_\_\_  
Printed Name of Parent/Guardian Parent/Guardian Signature Date

\*\*\*\*\*

Office Use Only: Completed: Reg \_\_\_\_\_ Perm \_\_\_\_\_ Med \_\_\_\_\_ Conduct \_\_\_\_\_ Travel: \_\_\_\_\_ Pub \_\_\_\_\_

Date Rec'd \_\_\_\_\_

**CODE OF CONDUCT**



# *Authorization for Emergency Medical Treatment*

## **Both sides of this form must be completed.**

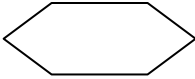
This information will be kept in the possession of Holy Family Parish Lincoln, Illinois YOUTH MINISTRY and distributed to the person in charge of this activity. Should the need arise, this information will be given to the proper medical authorities.

I, \_\_\_\_\_, understand that in the case of illness/accident of my  
(name of parent/guardian)  
child, \_\_\_\_\_, Holy Family Parish, will try to  
(Name)

notify me or the person I have listed as an emergency contact.

In case of medical emergency concerning my child, at a time when I or my listed emergency contact cannot be notified, I grant full power to HOLY FAMILY PARISH and/or any supervising employee to do as follows:

1. Arrange for the transportation of my child, whether by ambulance or otherwise, to a proper facility where emergency medical treatment would normally be administered, including but not limited to, an emergency room of a hospital, a doctor's office, or a medical clinic; and
2. Sign releases as may be required in order to obtain any medical or surgical treatment as is required in the judgement of medical authorities at the facility.



**Please do not sign this form until you are in the presence of a registered Notary Public.**

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Printed name of Parent/Guardian

Date: \_\_\_\_\_

STATE OF ILLINOIS     )  
  )SS.  
County of \_\_\_\_\_)

SIGNED AND SEALED before me this \_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

\_\_\_\_\_  
NOTARY PUBLIC

# MEDICAL INFORMATION

**Participant's Name** (first, middle, last): \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_  
(street) (City) (State) (Zip)

## **Emergency Contacts**

**Parent Name:** \_\_\_\_\_ **Parent Name:** \_\_\_\_\_

Home Phone: (\_\_\_\_\_) \_\_\_\_\_ Home Phone: (\_\_\_\_\_) \_\_\_\_\_

Work Phone: (\_\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_\_) \_\_\_\_\_

Cell Phone: (\_\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_\_) \_\_\_\_\_

## **Other Contact**

**Name:** \_\_\_\_\_ Relationship (friend, relative, neighbor, etc.): \_\_\_\_\_

Home Phone: (\_\_\_\_\_) \_\_\_\_\_ Wk Phone: (\_\_\_\_\_) \_\_\_\_\_ Cell: (\_\_\_\_\_) \_\_\_\_\_

**Participant's Regular Physician:** \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_

Local Preferred Hospital: \_\_\_\_\_

## **Medical Conditions**

**Please list any medical conditions of the above participant (asthma, diabetes, epilepsy, etc.):** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Please list any allergies or allergic reactions to medications of the above participant:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Please list any medications the above participant is now taking:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Other pertinent medical information:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Date of participant's most recent tetanus shot:** \_\_\_\_\_

**Medical Insurance Information:** Company: \_\_\_\_\_

Identification # of plan: \_\_\_\_\_ Identification # of covered employee