

Name of Parish _____

PARENTAL CONSENT AND EMERGENCY MEDICAL RELEASE FORM

I/We the parent(s) of: *(please print)* _____ do hereby give my/our approval for him/her to participate with the **Come & See at St. Joseph College Seminary** that is sponsored by the Archdiocese of Atlanta Office of Vocations. I/We do hereby, for myself, my heirs, executors, and administrators, waive, release, absolve, indemnify and agree to hold harmless any and all adults who chaperon, also the Archdiocese and its representatives, successors, supervisors, sponsors, organizers and participants for any injuries in connection with the program named above. I likewise release from my responsibility any person transporting my child to and from any of the activities. I/We hereby grant permission for publication of group (two or more persons) photos taken at youth events.

I/We also give permission to seek any emergency care should my child be involved in any accident or be injured in any way during such events named above. I/We understand that in any such instance, all attempts will be made to contact the parent/guardian. In the event that I/we cannot be contacted, I/we hereby give permission to the attending physician to hospitalize, secure treatment for, and to order injection, anesthesia, and/or surgery for my child, as named herein.

I also agree that I am legally responsible for all/any personal actions taken by my child/guardianship during this event, and agree to be financially responsible for any/all damages, legal fees, and other costs incurred as a result of the actions/behavior of my child/guardianship.

Furthermore, I/we agree that if the above named student's behavior is inappropriate, unsafe and/or detrimental to the group, I will be contacted immediately to secure means of removing my child/guardianship from the event premises. I understand that any financial costs incurred as a result of my child/guardianship being sent home are my responsibility.

Insurance Carrier: _____ **Policy #:** _____

Insurance Phone #: _____ **Child's Birthday:** _____

Parent Cell: _____ **Parent Name:** _____

_____ By initialing here, I grant permission for non-prescription medications to be given, if deemed appropriate by adult chaperone(s).

My child is allergic to: _____ **Current medication (and dosage):** _____

Other medical, physical, or general information: _____

In Emergency, Notify: _____ **Phone:** _____ **Relation:** _____

Parent/Guardian signature: _____ **Date:** _____

Printed Name: _____ **Relationship:** _____

In signing this form, I certify that all information contained herein is true and accurate to the best of my knowledge.