

# Faith Factor

## PARENTAL/GUARDIAN CONSENT FORM AND LIABILITY WAIVER

Participant's name: \_\_\_\_\_

Birth date: \_\_\_\_\_ Sex: \_\_\_\_\_ Grade in Fall 2010: \_\_\_\_\_

Parish: \_\_\_\_\_ Adult Shirt Size: \_\_ Sm \_\_ M \_\_ L \_\_ XL \_\_ XXL

Parent/Guardian's name: \_\_\_\_\_

Home address: \_\_\_\_\_

Home phone: \_\_\_\_\_ Business or cell phone: \_\_\_\_\_ Email: \_\_\_\_\_

I \_\_\_\_\_, request that the Faith Factor allow my/our son/daughter  
Parent or Guardian Name

\_\_\_\_\_ to participate in the "Faith FACTOR" service week with the  
Child's Name

Fox Valley Catholic Youth Ministry Association (FVCYMA) from July 13-15, 2010. The event is for service, community bonding & spiritual growth. This camp may require transportation to a location away from the parish site. This activity will take place under the guidance and direction of Faith Factor staff and/or adult chaperones.

As parent and/or legal guardian, I remain legally responsible for any personal actions taken by the above named minor ("participant"). I agree on behalf of myself, my child named herein, or our heirs, successors, and assigns, to hold harmless and defend Faith Factor, FVCYMA, the participating parishes, its advisors/chaperones, officers, directors and agents, and the Catholic Diocese of Green Bay, or representatives associated with the activity for reasonable attorney's fees and expenses arising in connection therewith. I further release any liability in the event my son/daughter is injured while participating in and/or traveling to and from the event in the rented or personally owned vehicles. The undersigned parent consents to the use of likeness in any manner relating to communication production in any media.

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

\_\_\_\_\_  
Date

We are going to be splitting up into "service teams" during the week. You may know a friend who is signing up for the week. If you would like to be placed on the same team as him/her, please print his/her name below and we'll do our best to try and place you on the same team.

Friend's name: \_\_\_\_\_  
(Please limit yourself to one friend)

Parish: \_\_\_\_\_

**Parent:** \_\_\_\_ I would be willing to drive and chaperone. Please send me the form \_\_\_\_\_.

Please send payment and form to your Parish Youth Minister or Religious Education coordinator

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**MEDICAL MATTERS:** I hereby warrant that to the best of my knowledge, my child is in good health, and I assume all responsibility for the health of my child.

**Of the following statements pertaining to medical matters, sign only those that are applicable.**

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**Emergency Medical Treatment:** In the event of an emergency, I hereby give permission to transport my child to a hospital for emergency medical or surgical treatment. I wish to be advised prior to any further treatment by the hospital or doctor. In the event of an emergency, if you are unable to reach me at the above numbers, contact:

Name & relationship: \_\_\_\_\_

Phone: \_\_\_\_\_ Family doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

Family Health Plan Carrier: \_\_\_\_\_ Policy #: \_\_\_\_\_

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

**Other Medical Treatment:** In the event it comes to the attention of the parish, its officers, directors and agents, and the Catholic Diocese of Green Bay, coaches, chaperones, or representatives associated with the activity that my child becomes ill with symptoms such as headache, vomiting, sore throat, fever, diarrhea, I want to be called collect (with phone charges reversed to myself).

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

**Medications:** My child is taking medication at present. My child will bring all such medications necessary, and such medications will be well-labeled. Names of medications and concise directions for seeing that the child takes such medications, including dosage and frequency of dosage, are as follows: \_\_\_\_\_

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

No medication of any type, whether prescription or non-prescription, may be administered to my child unless the situation is life-threatening and emergency treatment is required.

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

I hereby grant permission for non-prescription medication (such as aspirin, throat lozenges, cough syrup) to be given to my child, if deemed appropriate.

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

**Specific Medical Information:** The parish will take reasonable care to see that the following information will be held in confidence. Allergic reactions (medications, foods, plants, insects, etc.): \_\_\_\_\_

Immunizations: Date of last tetanus/diphtheria immunization: \_\_\_\_\_

Does child have a medically prescribed diet? \_\_\_\_\_

Any physical limitations? \_\_\_\_\_

Has child recently been exposed to contagious disease or conditions, such as mumps, measles, chickenpox, etc.? If so, date and disease or condition:

\_\_\_\_\_  
You should be aware of these special medical conditions of my child:

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