Diocese of Orlando Parental/Guardian Consent Form & Liability Waiver
(This form is required for minors to attend an off property event or trip.)

Participant's Name:_____ Date of Birth:_____

Address_____ City/State/_____

Zip_____ Home Phone:_____

Parent/Guardian's Name:_____

Cell Phone:_____Work phone:_____

Other number where Parent/Guardian can be reached during event:_____

Consent & Liability Waiver

Important! To be filled out by the Parent/Guardian for youth under 18 years of age *and* individuals age 18 or older and in high school.

In consideration of the program in which my son/daughter will participate, I, as parent or guardian of my son/daughter, do hereby agree to allow my son/daughter to accompany (entity name) BMCHS to:

Event & Location: Sophomore Service Retreat - Become What You Receive
September 25 - Catholic Charities of Central Florida, Orlando, FL; October 2 - Resurrection Catholic Church, Winter Garden, FL

Date & Time: September 25 (Last names A through Melvin) and October 2 (Mendez through Z), 8:00 am -2:40 pm

☐ **Transportation Not Provided**

☒ **Transportation Provided**

Method of Transportation: Bus

I acknowledge that (entity name) BMCHS is providing transportation only from (entity name) BMCHS to and from the event. I acknowledge and assume the risk of this transportation for my child. My child must comply with (entity name) BMCHS rules and procedures. By granting this permission, I also waive any claims against, and RELEASE AND HOLD HARMLESS AND INDEMNIFY, (entity name) BMCHS, the Diocese of Orlando, and any of their religious, employees, volunteers, agents and representatives from any liability, claims, demands and causes of action arising out of or relating to any loss, damage or injury sustained in connection with or arising out of my child's participation in the program.

_____ _____

Parent/Guardian Signature Date

(must sign for any participant under 18 &/or 18 or older & in high school)

PARTICIPANT: In signing the line below I agree to abide by any/all policies established for this event/activity. Should I not be able to maintain the guidelines and expectations of the adults and my peers, I understand that there will be consequences for my actions, including being removed from the activity and being sent home at my parent/guardian's expense.

_____ _____

Participant's Signature Date

Insurance Information

☐ **No, I do not carry medical insurance at this time.**

☐ **I do carry medical insurance at this time.**

Insurance Carrier: _____

Name of Insured: _____

Insurance Policy Number: _____

Father's Name: _____ Day Phone: _____

Mother's Name: _____ Day Phone: _____

In the event the participant does not have insurance, payment in full for medical care becomes the responsibility of the participant's parent/guardian.

Diocese of Orlando Parental/Guardian Medical Information & Consent Form

Participant's Name:_____ Date of Birth:_____

Address_____ City/State/Zip_____

Home Phone:_____

Father's Name: _____ Phone: _____

Mother's Name: _____ Phone: _____

Emergency Contact Name: _____ Phone: _____

Language Spoken by Emergency Contact: _____

Medical Matters

I hereby warrant to the best of my knowledge, all the information provided is true and correct and I assume all responsibility for the health of my child. I understand it is my responsibility to update the Medical Information & Consent Form if there are any changes to my child's health. (*Please initial)* _____

Emergency Medical Treatment

In the event of an emergency, I hereby give permission to transport my child to a hospital/clinic for emergency medical or surgical treatment. (*Please initial)* _____

Family Doctor _____ Phone _____

Medications

I hereby **Grant Permission** for my child to be given the following provided medications. All medications must be well labeled. [NOTE: Any/all prescription medications must be in original pharmacy container with young person's name on the prescription label. Non-prescription/over-the-counter medications must be in original container with young person's name on the container.] I release and hold harmless (entity name) _____, the Diocese of Orlando and any other religious, employees, volunteers, agents and representatives from any injury or harm resulting from administering the medication.
(*Please initial)* _____

Names of medications and concise directions for seeing that the child takes such medications, including dosage and frequency, are as follows:

Medication: _____Dosage: _____ Administer: _____

Medication: _____Dosage: _____ Administer: _____

Medication: _____Dosage: _____ Administer: _____

Medical Conditions Information: (Reasonable steps will be taken to keep this information confidential, but it will be shared with Diocesan personnel and others, as warranted.)
My son/daughter:

- Is allergic to the following medications _____
- Has had an episode of the following or has been diagnosed with: ☐ Seizures ☐ Asthma ☐ Diabetic
- Has had allergic reactions to the following (foods, dyes, latex, etc.)_____
- Has had a medical surgery within the last six months? ☐ Yes ☐ No Still under doctor's care? ☐ Yes ☐ No
- Has a medically prescribed diet (*please explain*) _____
- Has the following physical limitations_____
- Immunizations current and up to date? ☐ Yes ☐ No Date of last tetanus/diphtheria immunization_____
- You should also be aware of these special medical conditions of my child: _____

Insurance Information

☐ **No, I do not carry medical insurance at this time.**

☐ **I do carry medical insurance at this time.**

Insurance Carrier: _____ Name of Insured: _____

Insurance Policy Number: _____

In the event the participant does not have insurance, payment in full for medical care becomes the responsibility of the participant's parent/guardian.

I fully understand the foregoing statements and sign this Medical Information & Consent Form knowingly, freely, and willingly.

_____ _____

Parent/Guardian Signature *(must sign for any participant under 18 &/or 18 or older & in high school)* Date