

**PARISH EVENT/TRIP PARENTAL PERMISSION  
& MEDICAL RELEASE FORM  
CONFIRMATION SERVICE PROJECT 2011**

\_\_\_\_\_  
Candidate's Name Age Sex

\_\_\_\_\_  
Address City State Zip Home Phone

\_\_\_\_\_  
Grade Birth Date E-mail (if address is new)

**Produce to People** 4/2, 5/14, 5/21, 6/18, 7/9, 8/27 7:45 AM-1:30 PM going to varied locations

**Food Bank Repack** 4/23, 6/11, 8/27 8:15 AM-1:30 PM Duquesne Food Bank Repack Center

**Senior Connection** 5/14, 6/25, 8/6 7:30 AM-TBD varied locations-will be notified by Site Leader ahead of time

\_\_\_\_\_  
Date(s) of Event Time(s) of Event Description/name of Event/Trip Including Location(s) to be visited

**NOTE: A PARENT/GUARDIAN MUST ALSO ATTEND.** Parent Name \_\_\_\_\_

**Permission for Child to Participate**

I/we, the parents or guardians of the above mentioned child, for myself/ourselves and for my/our child. Give permission for my/our child to participate in the above mentioned event/trip on the above written date.

**Medical Authorization**

In the event of any injury or illness to my/our child during his/her participation in this one-day (or less) program, I/we hereby give my/our permission for the necessary medical treatment to be given to my/our child. I/we agree that in case of injury to my/our child, we will apply my/our hospitalization and/or or accident insurance toward payment of the expenses incurred and will not look to the SS John & Paul Parish or any other program sponsor or volunteer for the payment of any medical costs or injury related costs.

\_\_\_\_\_  
Parent/Guardian Signature(s) Name(s) (Please Print) Date

\_\_\_\_\_  
Phone number(s) for emergency

\_\_\_\_\_  
Insurance Company Policy and/or ID number(s)

\_\_\_\_\_  
Name and phone number of person to call if parent is not available.

**ATTENTION: PLEASE COMPLETE REVERSE SIDE ALSO!**

**SS JOHN & PAUL CHURCH  
MEDICAL CONSENT TO TREAT**

Child's Name \_\_\_\_\_ Home Phone \_\_\_\_\_

**CONSENT TO TREAT**

I/We, the undersigned parent(s)/guardian of \_\_\_\_\_, a minor, do hereby authorize treatment of my/our child by a licensed medical physician in case of any accident or illness that may so arise, or any hospitalization necessary. This medical consent will remain effective until **(date)**\_\_\_\_\_.

\_\_\_\_\_  
Signature Father/Legal Guardian                      Date                      Phone(s) where you can be reached

\_\_\_\_\_  
Signature Mother/Legal Guardian                      Date                      Phone(s) where you can be reached

**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 in accordance with your wishes.)*

1) Medications: My child is taking medication at present. My child will bring all such medications necessary, and such medications will be well labeled. My child will be responsible to administer his/her own medication.

Name of medication, time, and dosage \_\_\_\_\_

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

2) I hereby grant permission for nonprescription medication (such as Tylenol, throat lozenges, cough syrup) to be given to my child if deemed advisable.

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

3) No medicating 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 \_\_\_\_\_

Known allergies: \_\_\_\_\_

Known physical limitations: \_\_\_\_\_

Medically prescribed dietary needs: \_\_\_\_\_

**ATTENTION: PLEASE COMPLETE REVERSE SIDE ALSO!**