Parent Consent Form Diocese of Maryland

Event Name/Description:_____

Event Date(s):_____ Begin Time:_____ End Time: _____

* *

Name of Participant:_____

D.O.B & Grade: _____ Gender: _____ T-Shirt SZ:_____

Address: _____

City: _____ State: _____ Zip: _____

Youth Cell #: _____ Email: _____

Parish: _____ Location:_____

Parent/Guardian Name:_____

Parent/Guardian Mobile:_____ Wk/Home:_____

Other Emergency Contact: _____Phone:_____

Insurance Company: _____

Primary Insured: _____ Relationship: _____

Group/Plan #: _____ Policy#: _____

Special Needs (medication, allergies, physical / dietary limitations?):_____

_____

Consent / Waiver / Release Please check boxes:

- if we can use your child in a photo promoting activities
- I hereby give permission to this youth to attend and participate in activities of the above named event
- I hereby give permission for this youth to ride in any vehicle designated by the adult in whose care this minor has been entrusted while attending and participating in this event.
- I understand the general guidelines of behavior – that the participant must respect and obey the instructions of the supervising adults and that NO alcohol, tobacco, illegal drugs, or sexual misconduct will be tolerated at the event – and that the supervising adults have the right to reasonably enforce the established rules of conduct.
- I will assume all transportation costs for the youth if problems occur during this event and s/he must be sent home. I will take no civil or legal action against the supervising adults for the normal care of the minor in their

charge.

- I am aware that the *Standards of Behavior for Child-& Youth-Related Programs* is available for me to review at www.youth.episcopalmaryland.org
- I understand that every effort will be made to contact me in the event of any accident or injury to my child. In the event I cannot be reached, I hereby authorize any supervising adult, in whose care this minor has been entrusted, to consent to whatever medical or surgical treatment may be necessary or advisable by the physician or nurse treating such injuries. I understand that I am responsible for the cost of all medical treatment that is administered.

Signatures

Participant Printed Name: _____

Participant Signature: _____ Date: _____

Parent / Guardian Printed Name: _____

Parent / Guardian Signature: _____ Date: _____

MEDICATION CHART							
		Dosage at Times to be Given					
Medication		Pre-Brkfast	Brkfast	Lunch	Dinner	Night	As Needed

Event Contact Person: Kate Riley
Phone Office: 1-800-443-1399
E-mail: kriley@episcopalmaryland.org