STATEMENT OF CONSENT & MEDICAL TREATMENT AUTHORIZATION FORM

I hereby consent to participation by my child on any St. Colette Youth Ministry sponsored one-day event or outing during the **2023-2024** school year. I understand that this event may take place away from the parish grounds and that my child will be under the supervision of a parish representative. I further consent to the transportation, if needed, by car or van on one of these one-day events.

In consideration of my child being allowed to participate in this field trip, I hereby agree on behalf of myself and my child, to release St. Colette Parish, the Roman Catholic (Arch)Diocese of Detroit, and any and all affiliated organizations, their employees, agents and representatives, including volunteer drivers (collectively "Releasees"), from any and all claims, including negligence, which may be asserted by me or my child, or on behalf of my child, arising from or relating to my child's participation in the field trip. In the event this release on behalf of myself and or my child is held to be invalid or unenforceable, I hereby agree to indemnify and hold harmless Releasees from any and all claims, including negligence, which may be asserted by me or my child, or on behalf of my child, arising from or relating to my child's participation in the field trip. This release or indemnification does not apply to claims for intentional misconduct or gross negligence; nor does this release or indemnification apply to the extent of commercial insurance coverage for any claim, but this Release or Indemnification shall apply to the extent of any self-insurance or deductible applicable to any claim.

I authorize St. Colette Parish to obtain necessary medical treatment for my child in case of illness, injury or accident, and I give permission for the release of medical records to an attending physician.

I understand that photography and/or video of participants may be procured during the event and used in promotional materials, etc. I consent to the use of images or likenesses of the aforementioned person, without names attached, for promotional purposes, by St. Colette Youth Ministry. **Initial _____**

I understand that teens may occasionally be shown movie or tv clips as part of event programming. I give consent for my child to be shown material that is rated PG-13, PG, or G. **Initial _____**

I understand that teens have been informed of the rules, which prohibit tobacco products **(including ALL forms of VAPING)**, drinking, drugs, and leaving the boundaries without permission. If there is any violation of the rules, teens will accept the consequences of their actions.

Student's Name: _____ Home Phone: _____

Address: _____

PARENTS/LEGAL GUARDIANS

_____

Father's Name Address

_____

Home Phone Work/Cell Phone

_____

Mother's Name Address

_____

Home Phone Work/Cell Phone

In past emergency room visits, this information has been requested:

_____

Father's Date of Birth Father's Employer

_____

Mother's Date of Birth Mother's Employer

Family Physician: _____ Phone:_____

Address: _____

My child can receive: _____ Tylenol/acetaminophen _____ Advil/Motrin/ibuprofen

List allergies, medical conditions, medications being taking, or other pertinent comments:

_____

_____

Food Allergy Information – Please list any food allergies and their severity (just can't eat or can't be in the same room), and any other dietary needs (vegetarian, gluten free, etc.)

_____

_____

Health Insurance Info

Company: _____Policy:_____

Group: _____ Contract: _____

List a secondary emergency contact who will assume care of your child if you cannot be reached.

Name: _____ Phone: _____ Relationship: _____

As parent/guardian, I do hereby authorize the treatment of a qualified and licensed physician of any condition which, in the opinion of the physician, is deemed necessary and appropriate. This authority is granted only after a reasonable effort has been made to reach me.

I further authorize the person who presents the minor to sign the Acknowledgment of Receipt of Notice Privacy Rights that may be presented by the physician or health care facility.

This authorization is completed and signed of my own free will with the sole purpose of authorizing medical treatment deemed necessary and appropriate by the treating physician.

Date: _____ Signed: _____

(Parent or Guardian)