Diocese of San Bernardino
Liability Waiver & Medical Release Form
Confirmation Classes

(Event Name/Date/Time:)

Participant's Name: ______________________ Sex: M F Birth Date: __________ Age: ____

Parent/Guardian Name: ______________________

Home Address: ______________________

City: ______________________ State: Zip:

Home Phone: ______________________ Cellular Phone: ______________________

Parish Name & City: ______________________

ADULTS ONLY - This box **- ADULTS ONLY**

Liability Waiver

I agree on behalf of myself, my heirs, successors, and assign to hold harmless the Diocese of San Bernardino, the youth ministry event program, their officers, directors, and agents from any liability for illness, injury or death arising from or in connection with me

attending **the** ______________________ on ______________________ I understand that this is

Event Name *Date*

an event sponsored by the ______________________ youth ministry office and that it is presented by and

Parish Name

through the Dioceses of San Bernardino.

In the event that I should require medical treatment and I am not able to communicate my desires to attending physicians or other medical personnel, I give permission for the necessary emergency treatment to be administered.

In case of an emergency and for permission for treatment beyond emergency procedures, please contact:

Name: ______________________ Relationship to me: ______________________

Day Time Phone: ______________________ Alternate Phone: ______________________

Signature *Date*

YOUTH ONLY– This box **- YOUTH ONLY**

Parent/Guardian/Conservator Permission and Liability Waiver

I, ______________________ grant my permission for my son/daughter, ______________________

Parent/Guardian/Conservator signature *Participant's Name*

to participate in the event named above. I understand that this is an event sponsored by the ______________________

Parish Name

youth ministry office and that it is presented by and through the Diocese of San Bernardino.

I understand that as parent/legal guardian, I remain legally responsible for any personal actions taken by my son/daughter. I agree on behalf of myself, my son/daughter named herein, our heirs, successors, and assigns to hold harmless, the Diocese of San Bernardino and its employees and/or volunteers from any and all claims for illness, injury, death and the cost of medical treatment therewith, arising from or in any way connected with my son's/daughter's attending the event named above.

Parent/Guardian/Conservator Signature *Date*

If you are unable to reach me, please contact: ______________________ Relationship to my child: ______________________

Home Phone: ______________________ Alternate Phone: ______________________

ADULT AND YOUTH PARTICIPANTS MUST FILL OUT MEDICAL RELEASE

Please fill out the information below OR attach a photocopy of your insurance card front and back.

Insurance Carrier: ______________________________

Policy Number: ______________________ **Insurance ID Number** ______________

To the best of my knowledge, I/my child ______________________, is in good health, and I assume all responsibility for the health of my child. In the event of a medical emergency, I give permission to transport my child/for my child to be transported to a hospital for emergency medical or surgical treatment. I wish to be advised prior to any further treatment by the hospital or doctor.

______________________________ ______________

Parent/Guardian/Conservator signature *Date*

Sign only those statements in section 1 - 4 which are true and in accordance with your wishes.

Medications:

1. I/My child takes no medication and will bring no medication with him/her.

______________________________ ______________

Parent/Guardian/Conservator signature *Date*

2. I/My child takes medication/s and will self-medicate. My child will bring all such medications necessary, and such medications will be clearly labeled.

I understand that my child will be required to turn all medication(s) over to a supervising adult designated to keep medication(s). I further understand that it will be my child's responsibility to present himself/herself at a location designated for returning medication(s) to my child at the frequencies/times listed below. I understand that the adult to whom my child surrenders the medication has no medical training and this adult will not measure dosages. My child will return the medication(s) to the adult after he/she self-medicates. At the conclusion of the event it will be my child's responsibility to pick up remaining medication(s), if any, at the self medication designated location. Names of medications and exact dosage and frequencies/times are as listed below:

____

______________________________ ______________

Parent/Guardian/Conservator signature *Date*

3. I/My child takes medication but is unable to self-medicate. The child's parent/guardian will provide and dispense any and all needed medications.

______________________________ ______________

Parent/Guardian/Conservator signature *Date*

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

______________________________ ______________

Parent/Guardian/Conservator signature *Date*

4 b. I grant permission for the following non-prescription medication to be given: **(EXCLUDING MEDICATIONS NAMED BELOW THAT MAY CAUSE ALLERGIC REACTION).**

Non-aspirin pain reliever Yes No Antihistamine Yes No Antacid Yes No Decongestant Yes No

Specific Medical Information for Self or Child

Allergic reactions to medications, foods, plants, insects, etc.: ______________________

Medications self/child currently takes: ______________________

Any physical limitations: ______________________

You should also be aware of these special medical conditions of my child. (Please attach a clear description to this form) ______________

____

Signature of Self/Parent/Guardian: ______________________