

**DIocese OF COVINGTON
PARENTAL/GUARDIAN CONSENT FORM AND LIABILITY WAIVER**

Participant's Name _____
 Birth Date _____ Sex _____
 Parent/Guardian's
 Name _____
 Home Address _____
 Home Phone _____ Business Phone _____

I, _____, grant permission for my child _____, to participate in this diocesan/parish youth ministry activity as described below that requires transportation to a location away from the parish sites. This activity will take place under the guidance and direction of diocesan/parish employees and/or volunteers from _____ (diocese/parish). If transportation is required during the activity, I give permission for my child _____ to ride with a driver 21 years or older.

As parent and/or legal guardian, I remain legally responsible for any personal actions taken by the above named minor ("participant").

I agree on behalf of myself, my child named herein, or our heirs, successors, and assigns, to hold harmless and defend (name of parish) _____, its officers, directors and agents, and the Diocese of Covington, chaperons, or representatives associated with the activity for any claim or damages to any person or property, arising from or in connection with my child attending the activity or in connection with any illness or injury or cost of medical treatment in connection therewith, and I agree to compensate the parish, its officers, directors and agents and the Diocese of Covington, chaperons, or representative associated with the activity for reasonable attorney's fees and expenses arising in connection therewith.

Parent/Guardian Signature _____ Date _____
(if under 18 yrs. of age)

Participant's Signature _____ Date _____

ACTIVITY INFORMATION

Activity _____ Date _____ Cost \$ _____
 Location _____ Phone (emergency) _____
 Starting Time _____ Meeting Place _____
 Ending Time _____ Meeting Place _____
 Type of Transportation _____ Contract Person _____ Phone _____
 Other Information _____

MEDICAL INFORMATION

Completed By Parent or Guardian - Please Print

Child's Name _____ Birthdate _____
 Allergies _____
 Medications _____
 Chronic Conditions (e.g. epilepsy, diabetes) _____
 Medical Insurance Company _____ Policy Number _____
 Member's Name _____ Home Phone _____ Work Phone _____
 Family Doctor _____ Phone _____