ARCHDIOCESE OF LOS ANGELES
SAINT JULIE BILLIART
SPORTS OR YOUTH ACTIVITY/SERVICE
PERMISSION FORM E.2.1

Youth Activity/Service: Six Flags Hurricane Harbor
Date of Activity: **July 16, 2016 depart 11am Return 4pm**
Address: **26101 Magic Mountain Pkwy, Valencia, CA 91355**

Transportation car pool
CHILD'S NAME: _____ PARISH: Saint Julie Billiart
ADDRESS: _____ PHONE: _____
(Street)
_____
(City & Zip Code)
SCHOOL _____ GRADE ____ BIRTH DATE _____

PARENT/GUARDIAN NAME _____ HOME PHONE _____
ADDRESS _____ WORK PHONE _____
_____CELL PHONE _____

PERSON(S) (OTHER THAN PARENT) TO NOTIFY IN CASE OF EMERGENCY
NAME: _____ PHONE: _____ CELL PHONE:_____
NAME: _____ PHONE: _____ CELL PHONE:_____

I, THE PARENT (GUARDIAN) OF THE ABOVE NAMED CHILD, HEREBY GIVE MY PERMISSION FOR HIS/HER PARTICIPATION IN THE YOUTH ACTIVITIES NAMED ABOVE. I AGREE TO DIRECT MY CHILD TO COOPERATE AND CONFORM TO DIRECTIONS AND INSTRUCTIONS OF PARISH, SCHOOL, OR ARCHDIOCESAN PERSONNEL RESPONSIBLE FOR YOUTH ACTIVITIES.

I AGREE THAT IN THE EVENT MY CHILD IS INJURED AS A RESULT OF HIS/HER PARTICIPATION IN THE ABOVE NAMED YOUTH ACTIVITIES, INCLUDING TRANSPORTATION TO AND FROM THESE ACTIVITIES, WHETHER OR NOT CAUSED BY THE NEGLIGENCE (ACTIVE OR PASSIVE) OF THE PARISH/SCHOOL OR ARCHDIOCESAN YOUTH ACTIVITES PROGRAM, OR ANY OF ITS AGENTS OR EMPLOYEES, RECOURSE FOR THE PAYMENT OF ANY RESULTING HOSPITAL, MEDICAL OR RELATED COSTS AND EXPENSES WILL FIRST BE HAD AGAINST ANY ACCIDENT, HOSPITAL, OR MEDICAL INSURANCE OR ANY AVAILABLE BENEFIT PLAN OF MINE OR OF MY SPOUSE.

I AM NOT AWARE OF ANY MEDICAL CONDITION OF MY CHILD THAT RENDERS IT INAPPROPRIATE FOR HIM/HER TO PARTICIPATE IN ANY SUCH ACTIVITY.

I HEREBY GIVE PERMISSION TO THE PHYSICIAN SELECTED BY THE YOUTH ACTIVITIES SUPERVISORY PERSONNEL THEN PRESENT TO RENDER MEDICAL TREATMENT DEEMED NECESSARY AND APPROPRIATE BY THE PHYSICIAN.

I, hereby, authorize the making of photographs, video, recordings, or other memorializing of said event and my participation therein, and the publication or other use thereof. I, hereby wave any right to compensation therefore or any right that I otherwise might have to limit or control such making use.
ADULT LEADERS: Daryl Hitt

PARENT SIGNATURE: _____ DATE: _____

HEALTH AND MEDICAL RELEASE FORM FOR YOUTH

Name_____ **Date of Birth**_____
Address_____ **Female**_____ **Male**_____
City_____ **Zip**_____ **Phone (____)**_____
Parish:_____ **City**_____

Is this participant in general good health and able to participate in all activities involved in this event?

YES_____ NO_____(If no, please submit a statement indicating limitations or serious medical conditions.)

Date: most recent physical exam: _____ Physician or Clinic:_____

Address_____ Phone: (_____)_____

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IMMUNIZATION HISTORY: (Please give dates) If all current- please check ALL CURRENT_____
DPT_____ DPT BOOSTER_____ TETANUS BOOSTER_____

ALLERGIES (Please write yes or no next to each)
Hay Fever_____ Asthma_____ Poison Ivy_____ Sulfa_____ Nuts_____
Penicillin_____ Bee Sting_____ Other_____
Medicines_____
If any of the above is yes, please submit a statement of how the child has been treated and with what medication. Any medication not able to be self-administered must be listed.

Operations or Serious
Injuries:_____ Dates:_____Please notify the event coordinator if this child is exposed to any communicable disease during the three weeks prior to activity.

Does the participant have any special dietary needs? If yes please list on a separate sheet.

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AUTHORIZATION TO CONSENT TO TREATMENT OF MINOR

I/We, the undersigned, parent(s) of _____a minor, do hereby authorize as agent(s) Daryl Hitt for the undersigned to consent to any X-Ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by and is to be rendered under the general or special supervision of any physician and surgeon licensed under the provisions of the Medicine Practice Act of the medical staff of any licensed hospital whether such diagnosis of treatment is rendered at the office of said physician or at said hospital.

It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required, but is given to provide authority and power on the part of our for said agent(s) to give specific consent to any and all such diagnosis, treatment or hospital care which the aforementioned physician in the exercise of his/her best judgment may deem advisable.
I agree that in the event my child is injured as a result of his/her participation in this event, including transportation to and from such activity through the negligence (active or passive) of the **[SAINT JULIE BILLIART]**, or any of any of its agents or employees, recourse for the payment of any resulting hospital, medical or related costs and expenses will first be had against any accident, hospital, medical insurance, or any available benefit plan of mine or my spouse.

I also, give my child permission to self-medicate except for medications which are listed below. I understand that any medications so listed will be dispensed by the Director of First Aid for St Julie's**]**.

Signature of parent(s)/Guardian:_____Date:_____

Emergency Telephone Number During Event (_____)_____ Alternate Telephone (_____)_____

Family Health Insurance Co:_____Policy No._____
(If possible please provide a copy of the insurance card)

Medications:

_____

_____

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