



**Holy Trinity Parish Youth**  
**Permission/Medical Release Form**

Youth full name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Preferred name: \_\_\_\_\_ Preferred pronoun: \_\_\_\_\_

Street address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Best phone # for youth: \_\_\_\_\_ Youth email: \_\_\_\_\_

Legal guardian 1 name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Best email: \_\_\_\_\_ Best phone: \_\_\_\_\_ Alt phone: \_\_\_\_\_

Legal guardian 2 name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Best email: \_\_\_\_\_ Best phone: \_\_\_\_\_ Alt phone: \_\_\_\_\_

Emergency contact 1 name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Best email: \_\_\_\_\_ Best phone: \_\_\_\_\_ Alt phone: \_\_\_\_\_

Emergency contact 2 name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Best email: \_\_\_\_\_ Best phone: \_\_\_\_\_ Alt phone: \_\_\_\_\_

Physician name: \_\_\_\_\_ Phone: \_\_\_\_\_

Clinic/Hospital: \_\_\_\_\_ Phone \_\_\_\_\_

Insurance company: \_\_\_\_\_ Policy#: \_\_\_\_\_

## Medical History

If necessary, describe in detail the nature and severity of any physical and/or psychological ailment, illness, propensity, weakness, limitation, handicap, disability, or condition to which you are subject and of which the staff should be aware, and what, if any, action of protection is required on account thereof. Submit this notification in writing and attach it to this form. Holy Trinity Parish will take reasonable care to see that the following information will be held in confidence. Some activities may be physically strenuous. If you desire to limit your participation in any way, please submit your wishes in writing prior to participation.

1. Is the participant in good health and able to participate in normal activities?  Yes  No  
If not, please submit a statement indicating limitations and/or restrictions.

2. Please give the date of the participant's most recent physical examination\*: \_\_\_\_\_

3. Immunization History\* (Please give dates)

Date of last tetanus shot: \_\_\_\_\_

4. Allergies

Pollens  Medications  Food  Insect bites

Please note specifics: \_\_\_\_\_

5. Has the participant ever suffered from or been treated for any of the following:

Asthma  Epilepsy/seizure disorder  Heart trouble  
 Diabetes  Frequently upset stomach  Physical handicap  
 Depression  Emotional/mental disorder

Other: \_\_\_\_\_

6. Operations, serious injuries, or major illnesses in the past year:

\_\_\_\_\_

Date(s): \_\_\_\_\_

7. Is the participant subject to chronic homesickness, emotional reactions to new situations (sleepwalking, bedwetting, fainting, etc.?)

\_\_\_\_\_

8. Has the participant recently been exposed to contagious disease or conditions, such as mumps, measles, chickenpox, etc.? If so, list date and disease or condition:

\_\_\_\_\_

9. Does the participant have a medically prescribed diet?  Yes  No

10. The participant is a  swimmer  non-swimmer

*\*This information is not required for the pilgrimage*

## Medical Treatment

*Emergency Medical Treatment:* In the event of an emergency, I hereby give permission to transport my child to a hospital for emergency medical or surgical treatment at my expense. I wish to be advised prior to any further treatment by the hospital or doctor. In the event that you are unable to reach me, such treatment may be administered if deemed necessary. In the event of an emergency, if you are unable to reach me at the numbers given above, please contact the emergency contact listed above.

Initials of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

*Other Medical Treatment:* In the event it comes to the attention of the parish, its staff, chaperones, or representatives associated with the activity that my child becomes ill with symptoms such as headache, vomiting, sore throat, fever, diarrhea, I want to be called collect (with phone charges reversed to myself).

Initials of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

*Medication:* My child is taking medication at present. My child will bring all such medications necessary, and such medications will be well labeled. Names of medications and concise directions for seeing that the child takes such medications, including dosage and frequency of dosage, are as follows:

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Initials of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

No medication of any type, whether prescription or non-prescription, may be administered to my child unless the situation is life-threatening and emergency treatment is required

OR

I hereby grant permission for non-prescription medication (such as aspirin products, e.g. acetaminophen or ibuprofen, throat lozenges, cough syrup) to be given to my child if deemed appropriate.

Initials of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Initials of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

## Parental/Guardian Consent and Liability for Minors

I, \_\_\_\_\_, grant permission for my child, \_\_\_\_\_, to participate in  
*Parent or guardian's name* *Child's name*

all Holy Trinity sponsored events including those that require transportation to a location away from the parish. This activity will take place under the guidance and direction of parish employees and/or volunteers from Holy Trinity Parish. 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 Holy Trinity Parish, its officers, directors, employees and agents, and the Diocese of Atlanta, its employees and agents, chaperones, or representatives associated with the event, from any claim arising from or in connection with my child attending the event or in connection therewith, and I agree to compensate the parish, its officers, directors and agents, and the Diocese of Atlanta, its employees and agents and chaperones, or representatives associated with the event for reasonable attorney's fees and expenses which my incur in any action brought against them as a result of such injury or damage, unless such claim arises from the negligence of the parish/diocese.

Initials of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

## Code of Conduct

We expect each participant to conform to these rules of conduct:

- No possession or use of alcohol, drugs, tobacco, or pornography.
- No fighting, weapons, fireworks, lighters, or explosives.
- No offensive or immodest clothing.
- No student my drive.
- No males in female sleeping quarters, and no females in male sleeping quarters.
- Participation with the group is expected.
- Respect property.
- Respect on another, staff, and leaders.
- Respect and comply with event schedules and with any other specific event rules established by leaders.

**Students who fail to comply with these expectations may be sent home at their parents' expense.**

I, the student, have read the rules of conduct, the above evaluation of my health, and permission to participate in Youth Group activities. I agree to abide by the stated personal limitations and code of conduct.

Initials of Student: \_\_\_\_\_ Date: \_\_\_\_\_

Initials of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

## Permission to Use Participant Photos

You have my permission to use said participant's photos for commercial purposes (e.g. advertising this event in flyers, on the Web, etc.)

Initials of Student: \_\_\_\_\_ Date: \_\_\_\_\_

Initials of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

## Statement of Truth and Accuracy

I hereby certify that all of these statements are true and accurate to the best of my knowledge.

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Student: \_\_\_\_\_ Date: \_\_\_\_\_