

(Please Print!) NAME \_\_\_\_\_

PARISH/SCHOOL \_\_\_\_\_ CITY \_\_\_\_\_

**RELEASE AND CONSENT FORM**

(This completed form is **required** for participation)

**PARENT**

I, \_\_\_\_\_; the undersigned, give my permission for my

Parent[ ] Legal Guardian[ ]

son/daughter \_\_\_\_\_ to attend the \_\_\_\_\_. It is understood that reasonable caution will be taken by those persons in charge to prevent injuries. In consideration of my child's being permitted to participate in the \_\_\_\_\_, I, personally and on behalf of my child, hereby release The Archdiocese of Washington, St. Pius X Church, St. Pius X school, all St. Pius X Church and School employees, chaperones, volunteers, and representatives associated with the \_\_\_\_\_ from any liability for injuries or damage arising or resulting from participation in the \_\_\_\_\_. We hereby agree to assume any risks of participation in the \_\_\_\_\_. In the event that I cannot be reached, I hereby grant permission for my son/daughter to be evaluated, diagnosed, treated and/or medicated in accordance with standard medical practice by licensed medical personnel.

My child agrees to abide by rules and regulations as outlined in the St. Pius X Code of Behavior. I understand that St. Pius X Church will not be held liable if my child fails to cooperate with said regulations and that any infractions of the rules may result in immediate dismissal from the event. I will be responsible for any costs or other requirements for immediate transportation home.

\_\_\_\_\_  
Parent or Legal Guardian signature

\_\_\_\_\_  
Date

**YOUTH**

As a member of the St. Pius X Youth Group, **I understand and agree to the Code of Behavior.** I also understand and agree that my parents or legal guardians will be notified at the time of any infractions requiring my dismissal from the \_\_\_\_\_ and that I will be sent home at my own and/or my parent/guardian's expense.

\_\_\_\_\_  
Youth Signature

\_\_\_\_\_  
Date

**MEDICAL INFORMATION (Please Print!)**

My child is allergic to  
(medication/food/other): \_\_\_\_\_

My child must take the following medication (indicate dosage, frequency, etc.)  
\_\_\_\_\_

You should be aware of these special medical conditions or needs of my child: (dietary, asthma, walking assistance, bee sting allergies, other concerns) \_\_\_\_\_

Please provide all necessary information about insurance.

Insurance Carrier: \_\_\_\_\_ Policy Carrier: \_\_\_\_\_

Policy Number \_\_\_\_\_ Benefit/Plan/Group Number \_\_\_\_\_

Date of last Tetanus Booster \_\_\_\_\_ Youth Social Security Number \_\_\_\_\_

In case of emergency notify: \_\_\_\_\_

Relationship to Youth \_\_\_\_\_ Daytime phone \_\_\_\_\_ Evening phone \_\_\_\_\_