

ST. BERNARD'S YOUTH GROUP

You can do all things through Christ who strengthens you

Philippians 4:13

Teen name/last name: _____ T-shirt size _____

Parent's Name: _____ completed medical form in the back

Parent's Number: _____ Parent's Email: _____

I give my child _____ permission to participate in all activities schedule throughout the year with St. Bernard's Youth Group (SBYG). I hold the parish and Diocese of Stockton harmless from any claim of injury, sickness or damage that my child may suffer or sustain during the activities. I am not aware of any medical condition which would render inappropriate for my child to participate in the activities. Any and all conditions that the staff needs to be aware are listed on the medical release form in the back. I give full consent to St. Bernard's youth group to publish any photographs or videos in which my teen appears while participating in the program.

Registration Fee for the year \$25.00 (checks payable to St. Bernard's Church)

Cash _____ Online _____ Check # _____

Parent Signature _____



YOUTH HEALTH AND MEDICAL RELEASE FORM

Name: _____ Date of Birth: _____
Address: _____ Female: _____ Male: _____
City: _____ Zip: _____

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 of most recent physical exam: _____ Physician: _____

Address: _____ Phone: _____

Are there any known allergies to food or medications that those who work with your young person this week should be aware of? Yes No

If yes, please explain: _____

Are there any known physical, psychological or emotional limitations that would affect this young person's participation in this event? Yes No

If Yes, please explain: _____

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.

My child is currently taking the following medication(s), which he/she will be bringing on this activity in well-labeled containers that include clear directions for dosage and frequency of usage. I hereby give permission the Designated Person(s) **SBYG CORE TEAM** to administer the following medication(s). I understand that any medications listed will be dispensed by the Director of First Aid for the **SBYG CORE TEAM . MEDICINES**

AUTHORIZATION TO CONSENT TO TREATMENT OF MINOR

I/We, the undersigned, parent(s) of _____ a minor, do hereby authorize as agent(s) **SBYG CORE team** 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, 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.

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

Emergency Telephone Number During Event : _____ Alternate Telephone: _____

Family Health Insurance Co: _____

Policy No.: _____