DIOCESE OF HARRISBURG
OFFICE FOR YOUTH AND YOUNG ADULT MINISTRY
PARENTAL PERMISSION AND CONSENT TO TREAT FORM

Participant's Name:_____ Birth date: ____/____/____ Grade**:** ____

Participant's Address: _____

_____

Parish: _____**School:** _____

Parent/Guardian's Name: _____

E-mail Address: _____

Home Address: (if different from above) _____

_____

Home Phone: _____ Work **Phone:** _____ **Cell Phone:** _____

I, _____, **grant permission for**
(Name of parent or guardian)

_____ **to participate**
(Name of child)
in the __2018/2019_____CYO basketball season where s/he will travel by car, van or bus to practices, games or tournaments.

I understand that the program will have competent adult supervision and reasonable and appropriate measures will be made to minimize the risk of injury and/or accident. I understand and have been informed that taking part in this youth activity or event involves the risk of injury.

I hereby grant consent for the coach, chaperon, and/or adult volunteer under whose auspices the program is conducted, to secure all necessary emergency medical care and/or treatment that may be necessary for my child during the entire youth trip/event including any necessary transportation, if provided by the coach, chaperon, or adult volunteer. I release and hold harmless any said coach, chaperon, or adult volunteer, from any liability, who in good faith is placed in a position requiring decisions to be made for emergency care or medical treatment of the above-named young person. In case of accident, injury or loss, neither my family nor I will hold the diocese, the parish, the place where the event is conducted, the group sponsoring the event, nor any person or affiliate organization associated with the event responsible or liable.

In the event of an emergency, if you are unable to reach me at the above number, contact:

Name and Relationship:_____

Phone: _____ **Additional Phones:**_____

Family Physician: _____ **Phone:**_____

Allergic reactions (medications, foods, insects, etc)_____

(Medication(s) currently being taken)_____

My child has special medical/mental conditions: Yes___ No ___ **(if yes, please describe on reverse side of form)**

Insurance Company: _____ **Policy Number:** _____

_____ _____/_____/_____ _____
Parent/Guardian Signature **Date** **Relationship to Participant**