

St. Michael's & St. Paul's Youth Ministries  
Senior High 2009-2010  
UNIVERSAL MEDICAL FORM & UNIVERSAL PERMISSION SLIP  
St. Michael's 356-4280, St. Paul's 732-5324

Name: \_\_\_\_\_

Phone: \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_\_

School: \_\_\_\_\_ Gr.: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

E-mail \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Daytime Phone \_\_\_\_\_ Cell: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Daytime Phone \_\_\_\_\_ Cell: \_\_\_\_\_

Doctor's Name: \_\_\_\_\_ Phone \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Allergies, Disease, Disorders, Disabilities? Please specify: \_\_\_\_\_

Will you be bringing and/or using any medication while on the trip? **Yes** or **No**

If YES, Please explain (All information CONFIDENTIAL):

Insurance Company and Policy Number: \_\_\_\_\_

Names & Phone numbers of 2 relatives and/or friends to contact if parents cannot be reached:

1. Name: \_\_\_\_\_ Phone: \_\_\_\_\_

2. Name: \_\_\_\_\_ Phone: \_\_\_\_\_

**FOR PARENTS:**

I give permission for my child \_\_\_\_\_ to take part in the SENIOR HIGH YOUTH MINISTRY PROGRAM 2009-2010 sponsored by Churches of St. Michael's and Church of St. Paul's. In consideration of the opportunity for my child to participate and fully recognizing that such an undertaking involves an element of risk, we assume all risks and hazards incidental to such participation and so hereby release, absolve, indemnify and agree to hold harmless the Archdiocese of St. Paul and Minneapolis, the Churches of St. Michael's and St. Paul's, their agents, employees and officers, and the chaperones, leaders, organizers and sponsors and the person transporting our child to and/or from these activities. Neither the Archdiocese of St. Paul and Minneapolis, the Church of St. Michael and St. Paul's, nor any of said persons shall be held financially responsible for any injury, illness or death incurred as a direct result of this activity. We, the undersigned, have read this release and understand all its terms and execute it voluntarily and with full knowledge of its significance. In the event of an emergency and we cannot be contacted, we hereby authorize that emergency treatment may be administered.

I UNDERSTAND IF THERE ARE ANY CHANGES DURING THE YEAR 2009-2010 IT IS THE PARENTS OR YOUTHS RESPONSIBILITY TO UPDATE THIS INFORMATION WITH THE CHURCHES OF ST. MICHAEL'S AND ST. PAUL'S YOUTH MINISTRY.

PARENT SIGNATURE: \_\_\_\_\_

Medical Matters: I hereby warrant that to the best of my knowledge, my child is in good health, and I assume all responsibility for the health of my child. (Of the following statements pertaining to medical matters, sign only those that are applicable.)

Medical Treatment: In the event it comes to the attention of the parish, its officers, directors and agents, and the Archdiocese of St. Paul and Minneapolis, 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.

Signature \_\_\_\_\_ Date \_\_\_\_\_

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Medications: My child is taking medication at present. My child will bring all such medications necessary, and such medications will be well-labeled. Name of medications and concise directions for seeing that the child takes such medications, including dosage and frequency of dosage and the medications will be given to the Director of Faith Formation or the person in charge of said event for distribution.

Signature \_\_\_\_\_ Date \_\_\_\_\_

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**Please read carefully and select one of the following options:**

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

Signature \_\_\_\_\_ 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.

Signature \_\_\_\_\_ Date \_\_\_\_\_