

**PARENTAL/GUARDIAN CONSENT FORM AND LIABILITY WAIVER**

Name of Minor ("Participant"): \_\_\_\_\_

Home Address: \_\_\_\_\_

\_\_\_\_\_

Home Phone: \_\_\_\_\_ Business Phone: \_\_\_\_\_

Parent(s)/Guardian(s) Name(s):

I/we, \_\_\_\_\_

Parent(s) Or Guardian(s) Name

grant permission for my/our child, \_\_\_\_\_

Participant's Name

to participate in this parish activity. My child will \_\_\_\_\_ or will not \_\_\_\_\_ be staying for the **Lock-IN**.

This activity will take place under the guidance and direction of **QUEEN OF PEACE** employees and/or volunteers.

A brief description of the activity follows:

Type of event: **LOCK IN – CORN MAZE**

Location(s): **QUEEN OF PEACE CHURCH – CORN MAZE @ CHATFIELD**

Individual(s) in charge: **NORMA ROCHFORD, ANDY LIGHT & ADULT CORE TEAM**

Duration of activity: **FRIDAY – OCTOBER 28, 2011**

Cost: **\$10.00 – Permission Slip & Money Due October 23**

Mode of transportation to and from event: **ADULT TRANSPORTATION & QOP BUS**

As parent(s) and/or legal guardian(s), I/we remain legally responsible for any personal actions taken by the above-named Participant.

I/We further agree to defend, indemnify and hold harmless the Archdiocese of Denver and the parish as well as any of its affiliated agencies and their respective agents, directors, officers, employees, and volunteers from any and all claims or demands made for damage, loss, illness or injury to the above-named Participant.

Signature: \_\_\_\_\_  
Parent Or Guardian

Date: \_\_\_\_\_

Signature: \_\_\_\_\_  
Parent Or Guardian

Date: \_\_\_\_\_

**MEDICAL MATTERS**

The parish will take all reasonable and prudent care to see that confidentiality regarding the following information is maintained.

I/We hereby warrant that to the best of my/our knowledge, my/our child is in good health, and I/we assume all responsibility for the health of my/our child. I/We understand and acknowledge that any medical expenses related to illness or injury to my/our child are not covered by any insurance program maintained by the Archdiocese of Denver, and that I/we am/are responsible for such expenses.

**Emergency Medical Treatment:** In the event of an emergency, I/we hereby give permission to transport my/our child to a hospital for emergency medical or surgical treatment. I/we wish to be advised prior to any further treatment by the hospital or doctor. In the event of an emergency, if you are unable to reach me/us at the above numbers, contact: \_\_\_\_\_

Name of Minor ("Participant"): \_\_\_\_\_

Sex: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Name of Parent(s)/Guardian(s): \_\_\_\_\_

Emergency Phone: \_\_\_\_\_

Family doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

Family Health Plan Carrier: \_\_\_\_\_

Policy #: \_\_\_\_\_

Allergic reactions (medications, foods, plants, insects, etc.): \_\_\_\_\_

Immunizations: Date of last tetanus/flu immunization: \_\_\_\_\_

Does Participant have a medically prescribed diet? \_\_\_\_\_

Any physical limitations? \_\_\_\_\_

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

\_\_\_\_\_  
\_\_\_\_\_

Other special medical conditions:

\_\_\_\_\_  
\_\_\_\_\_

**Medications:** Participant is taking medication at present.

Yes \_\_\_\_\_ No \_\_\_\_\_

It is Participant's responsibility to bring all necessary medications, and to ensure they are clearly labeled. **Instructions from the Participant's family physician for these medications must be attached to this form.** The instructions must include the name, concise dosing directions, purpose of, and proper storage of and for all medications.

NOTE: Parish staff and volunteers WILL NOT administer ANY medications requiring the use of a syringe or other needle delivery system. Alternate accommodations for must be made for these circumstances and the parish fully informed of the nature of such accommodations.

**Notice:** I want to be contacted in the event it comes to the attention of the parish, its officers, directors and agents, and the Archdiocese of Denver, chaperones, or representatives associated with the activity that Participant experiences symptoms such as headache, vomiting, sore throat, fever, diarrhea, etc.

Yes \_\_\_\_\_ No \_\_\_\_\_

**I/We hereby grant** permission for the following non-prescription medication (non-aspirin products such as acetaminophen or ibuprofen, throat lozenges, cough syrup, etc.) to be administered to the Participant, if deemed appropriate.

Yes \_\_\_\_\_ No \_\_\_\_\_

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**OR: 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.

Yes \_\_\_\_\_ No \_\_\_\_\_

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Signature: \_\_\_\_\_  
Parent Or Guardian

Date: \_\_\_\_\_

Signature: \_\_\_\_\_  
Parent Or Guardian

Date: \_\_\_\_\_