# ROMAN CATHOLIC DIOCESE OF BURLINGTON

**Office of Youth and Young Adult Ministry**
55 Joy Drive, South Burlington, Vermont 05403
(802) 658-6110

## ***YOUTH*** REGISTRATION, MEDICAL RELEASE AND PERMISSION COMBINED FORM

Event Name: __STEUBENVILLE EAST 2020_____

***(Please print or type all information, except signatures)***

**I. Youth Information**

First Name: _____ Middle Initial: _____ Last Name: _____

Address: _____

City, State, Zip: _____ Home Phone: _____

Email address: _____ T- Shirt Size: S M L XL 2X

Parish trust/School (group you are registered with): _____

Mother/Guardian: _____ Father/Guardian: _____

Additional Emergency Phone numbers (please identify as work, cell, pager, etc.): _____

Date of birth: _____ Age: _____ Grade: _____

**Circle ALL that apply:** Male Female Mobility Impaired Wheelchair Access

Hearing Impaired/Interpretation Needed Visually Impaired (more than wearing glasses)

Please note: All areas utilized are not ADA accessible. Contact your Event Leader for special arrangements.

**II. Youth Agreement**

I understand that my participation in this program requires compliance with specific regulations for this event. I agree to abide by all rules and regulations set forth. Any infraction of the rules or regulations, including, but not limited to, the possession of alcohol, drugs, or weapons may cause my dismissal from the program. If I should be dismissed, I understand that my parents will be contacted to arrange for my immediate transportation home.

Youth Signature: _____ Date: _____

**III. Parental Agreement**

I, the parent/guardian of _____, who is less than eighteen years of age, grant permission for my daughter/son to participate in __Steubenville East 2020. By allowing my child to participate in the said program, I hereby assume all risk of accident or harm arising or growing out of, directly or indirectly, any incident of any kind occurring during the course of such program to my child and do hereby release and discharge the Diocese of Burlington, and _____ parish trust/school, and the agents, associates, and employees of the Diocese of Burlington and parish trust/school who have organized or participated in the supervision of such program from all claims, demands, suits, causes or actions, rights, costs, expenses, and any compensations whatsoever which may occur to my family and its members during or resulting from participating in the program mentioned.

**Signature:** _____ **Date:** _____

I am aware of the particulars of the said program including the times, costs, and adults chaperoning and/or transporting my child for the program and have clarified any concerns I may have with the coordinating adult in charge. I agree that my son/daughter shall abide by the rules and all regulations of the program including in regards alcoholic beverages, drugs, and weapons. I agree that if my son/daughter fails to abide by the regulations set forth, he/she may be dismissed from the program and I will need to arrange for his/her immediate transportation home at my expense.

**Signature:** _____ **Date:** _____

☐ I grant to the Diocese of Burlington, its directors, officers, employees, staff members, faculty, representatives, volunteers and agents the right to take photographs of my son or daughter and their property in connection with the event named below. I authorize the Diocese of Burlington, its assigns and transferees to copyright, use and publish the same in print and/or electronically.

I hereby authorize that the Roman Catholic Diocese of Burlington or the parish trust/school named on the registration form to use the name, voice and likeness of my son or daughter in any manner, form or way relating to communication production in any media, and I hereby release these entities from any and all claim associated therewith in connection the _____.
***(Event Name)***

**Signature:** _____ **Date:** _____

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**IV. Medical Information**

***(Please read all the options below, then check and sign only those that are in accordance with your wishes.)***

☐ In the event of an emergency, I hereby grant permission to transport my son/daughter and obtain emergency medical or surgical treatment(s) from a licensed physician, hospital, or medical clinic. I hereby authorize medical personnel to release necessary information about his/her care to the parish trust or school group leaders(s) named here _____. I wish to be advised prior to further treatment by the hospital
*(Event leader names)*
Or in the event that I cannot be reached, please contact _____at_____
*(Emergency Contact Name)* *(Emergency Contact Phone Number)*
Relationship to youth: _____.

Family physician: _____ Physician Phone Number: _____.

***(Please check one of the following)***

☐ My son/daughter is covered by hospitalization and medical insurance under policy # _____ _____ issued by _____.

☐ My son/daughter does not have medical coverage and I assume responsibility for the cost of hospitalization and medical care for my son/daughter.

**Signature:** _____ **Date:** _____

☐ My son/daughter is taking medications at present. He/she will bring all necessary medications and such medications will be well labeled. The names of, and concise directions for taking such medications, including dosage and frequency of dosage are as follows:

Medication: _____ Dosage: _____

Medication: _____ Dosage: _____

**Signature:** _____ **Date:** _____

☐ No medication of any type whether prescription or nonprescription may be administered to my child unless the situation is life threatening and emergency treatment is required.

**Signature:** _____ **Date:** _____

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☐ I hereby grant permission for nonprescription medication (such as acetaminophen, decongestant, cough syrup) to be given to my son/daughter, if requested by my son/daughter and deemed advisable by an adult chaperone.

**Signature:** _____ **Date:** _____

☐ I wish to inform you of the following additional medical information and the recommended course of action (allergies, dietary restrictions, special conditions, etc.)_____

_____

**Signature:** _____ **Date:** _____

☐ I would like to have a member of the program staff speak with me further regarding a medical concern or situation. Please contact me at _____.