

DIOCESE OF LITTLE ROCK ~ OFFICE OF CATHOLIC SCHOOLS
IMMACULATE CONCEPTION CATHOLIC SCHOOL
PARENT/GUARDIAN LIABILITY WAIVER AND MEDICAL CONSENT

Student's Name: _____ Date of Birth: _____
 Home Address: _____
 City: _____ State: _____ ZIP Code: _____
 Phone: _____ ☐ Cell Phone ☐ Work
 Alternate Phone Number: _____
 School: _____ Grade: _____ Age: _____ Sex ☐ M ☐ F

LIABILITY WAIVER

Important! To be filled out by the Parent/Guardian for youth under 18 years of age. If participant is 18 years of age or older, consent must be signed by the individual.

I (name of parent/guardian) _____, grant
 permission for my child, (participant's name) _____, to participate
 in the _____ (event), to be held _____ (date) _____
 (time) _____ (place). _____ (mode of transportation)

I agree on behalf of myself, my child's other parent if known, or living (name of other parent)
 _____.

My child named herein, or our heirs, successors, and assigns, agree to hold harmless and defend the
 Diocese of Little Rock, the sponsoring parish (its pastor, principal, teacher, youth minister, other agents,
 etc.) or any representatives associated with the scheduled activity unless the parties involved were careless
 or negligent.

 Signature (Parent/Guardian) _____ Date: _____

 Signature of participant if 18 years old or older _____ Date: _____

Please complete the Medical Consent on the back of this waiver.

MEDICAL CONSENT

Name of Student: _____

Medical Matters

I hereby warrant 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 in accordance to your wishes:

Emergency Medical Treatment

In the event of any emergency, I hereby give permission to transport my child to a hospital for emergency medical or surgical treatment. I wish to be advised prior to any further treatment by the hospital or doctor. In the event of any emergency when you are unable to reach me, contact:

Name & Relationship _____ Phone _____

Family Doctor _____ Phone _____

Medications

My child will bring all medications, well labeled, that are necessary. Names of medications and concise directions for seeing that the child takes such medications, including dosage and frequencies are as follows:

My child is taking the following medication at the present time:

Medication(s) _____ Dosage _____

Medication(s) _____ Dosage _____

Administer _____

_____ I hereby DO NOT GRANT PERMISSION for medication of any type, whether prescription or nonprescription to be administered to my child unless the situation is life threatening and emergency treatment is required. (Please initial)

_____ I hereby GRANT PERMISSION for nonprescription medication provided by the parent(s)/guardian(s) (such as Tylenol, throat lozenges, cough syrup) to be given to my child, if deemed advisable. (Please initial)

MEDICAL CONDITIONS INFORMATION

(Diocesan personnel will take reasonable care to see that the following information will be held in confidence.)

My child has _____

Has had an episode of the following or has been diagnosed? ☐ Seizures ☐ Asthma ☐ Diabetic

Allergic reactions to the following (foods, dyes, latex, etc.) ? _____

Has had medical surgery within the last six months? ☐ Yes ☐ No Still under Doctor's care? ☐ Yes ☐ No

Has a medically prescribed diet? _____

The following physical limitations? _____

Immunizations current and up to date? ☐ Yes ☐ No

Date of last tetanus/diphtheria immunization? _____

You should be aware of these special medical conditions of my child. _____

INSURANCE INFORMATION

Insurance Carrier _____

Name of Insured _____

Insurance ID Number _____ Insurance Policy Number _____

Father's Name _____ Birth Date _____

Place of Employment _____

Mother's Name _____ Birth Date _____

Place of Employment: _____

☐ No, I do not carry medical insurance at this time.

In the event it comes to the attention of the chaperones associated with the activity that my child becomes ill with repeated symptoms such as headache, vomiting, sore throat, fever, or diarrhea, I want to be called immediately.

Signature (Parent/Guardian) _____

Date _____