2023 Mission Trip
June 11-16, 2023

In cooperation with Catholic Heart Work Camp

YOUTH Registration, Medical Release/Permission Form

(Please type or print in ink all information, except signatures and complete both sides of this form.)

First Name ______________________ Middle Initial ______ Last Name ____________________________

Address ____ Date of Birth (mm/dd/yy) _______________

City, State, Zip ____

Home Phone ____Cell Phone___________________________

Mother/Guardian Name __________________________________Cell Phone __________________________

Father/Guardian Name ___________________________________Cell Phone __________________________

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:** ______________________

Parental Agreement

I, the parent/guardian of ____________________________________who is less than nineteen years of age, grant permission for my daughter/son to participate in the **Mission Trip** from **June 11-16, 2023** with **Holy Spirit Parish**. 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 Bishop of the Diocese of Youngstown, and Holy Spirit Parish, and the agents, associates, and employees of the Bishop and parish 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 to 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 understand that information about the event (including participant's names) may periodically be included in parish, local, and/or diocesan publications. I understand that photographs or video taken at this event may be used in parish or diocesan publications.

Signature: ____ **Date:** ______________________

I hereby authorize the parish/group to communicate directly with my child, or indirectly through me, via:

Cell phone calls & text message; cell number (s)____

Email; at this address(es)____

Signature: ____ **Date:** ______________________

PLEASE COMPLETE REVERSE SIDE

Medical Information

(Please check and sign ONLY those below which are in accordance with your wishes; do <u>not</u> sign all sections.)

Select this:

☐ In the event of an emergency, I hereby grant permission to transport my son/daughter and obtain emergency medical or surgical treatment from a licensed physician, hospital, or medical clinic. I hereby authorize medical personnel to release necessary information about his/her care to group leaders Mark Violand and Claire Hobbs of Holy Spirit Parish. I wish to be advised prior to further treatment by the hospital or doctor. In the event I cannot be reached, please contact

Name: ____ Phone: __________________________

Relationship to youth _________________________________

Family physician _____________________________________ Phone ______________________

(*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: ____________________

Or this:

☐ I hereby warrant that to the best of my knowledge, my son/daughter is in good health. **I do not want any medical treatment to be given to my son/daughter under any circumstances.** I hereby assume all responsibility for the health and well-being of my son/daughter and release from responsibility the Bishop of the Diocese of Youngstown, and Holy Spirit Parish, and the agents, associates, and employees of the Bishop and parish who have organized or participated in the supervision of such program.

Signature: ____ Date: ____________________

Select this:

☐ 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: ____________________

Or this:

☐ 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: ____________________

☐ 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 the concise directions for taking such medications, including dosage and frequency of dosages are as follows:____

____

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 the Holy Spirit Parish group leader speak with me further regarding a medical concern or situation. Please contact me at __________________________.

NOTARY (REQUIRED) City/County of ____________________; State of _______________________

On this _______ day of ______________, ________, before me personally appeared the adult named hereinabove, who is personally known to me or produced positive identification, and who executed the foregoing Registration, Medical Release/Permission Form, and acknowledged that he/she executed the same as his/her free act and deed.

[Notarial Seal] Signature of Notary Public _________________________________

My commission expires __________________________________