

SILVER RING THING

Diocese of Pittsburgh

January 15, 2010

NAME _____ AGE _____ GENDER _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____ PHONE _____ (____)

SCHOOL _____ GRADE _____ BIRTHDATE _____

PARISH _____

PERMISSION

I/we, the parents or guardians of the above mentioned child, for myself/ourselves and for my/our child, give permission for my/our child to participate in the above mentioned event, at Seton-LaSalle Catholic High School, on the above written dates.

MEDICAL AUTHORIZATION

In the event of any injury or illness to my/our child during his/her participation in this event, I/we hereby give my/our permission for the necessary medical treatment to be given to my/our child

I/we agree that in case of injury to my/our child, I/we will apply my/our hospitalization and/or accident insurance toward payment of the expenses incurred and will not look to the Secretariat for Education, Seton-LaSalle Catholic High School, the Catholic Institute, or the Roman Catholic Diocese of Pittsburgh for the payment of any medical costs or injury related costs.

Parent/Guardian Signature _____ Parent/Guardian Phone Number _____

Insurance Company _____ Policy Number _____

Name and Phone Number of Person if parent/guardian is not available _____

*** The group leader is to keep these during the entire event.**

CONSENT TO TREAT

I/We the undersigned parent(s)/guardian of _____, a minor, do hereby authorize treatment of my/our child by a licensed medical physician in case of any accident or illness that may so arise, or any hospitalization necessary.

Father/Legal Guardian

Mother/Legal Guardian

Date: _____ This consent form will remain effective until the end of the event.

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 in accordance with your wishes...

- 1) **Medications:** My child is taking medication at present. My child will bring all such medications necessary, and such medications will be well labeled. My child will administer his/her own medication.

Signature: _____ Date: _____

- 2) I hereby grant permission for nonprescription medication (such as Tylenol[®], throat lozenges, cough syrup) to be given to my child, if deemed advisable.

Signature: _____ Date: _____

- 3) No medicating 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: _____

Any known allergies?: _____

Any physical limitations?: _____

Any medically prescribed dietary needs?: _____

Are you a vegetarian? YES NO

Is child subject to chronic homesickness, emotional reactions to new situations, fainting?
 YES NO

If yes explain: _____