Diocese of San Jose **Student Activity Waiver Form**

General Liability

PARISH/SCHOOL INFORMATION	
Location Name: St. Thomas Aquinas Parish—Our Lady of the Rosary Site: Dermody Center	**Location #**:
Location Address: 3290 Middlefield Road, Palo Alto, CA 94306	Telephone: (650) 494-2496 Ext. 21
Contact Name: Michael Sullivan	Facsimile: (650) 494-3780
NOTICE TO ADMINISTRATORS/SUPERVISORS: THIS FORM MUST BE COMPLETED AND COPY FILED WHEN A STUDENT PARTICIPATES IN AN ACTIVITY SPONSORED BY THE SCHOOL OR PARISH. *REFER ANY QUESTIONS TO RISK & INSURANCE MANAGEMENT TELEPHONE: 408-983-0250 / FACSIMILE: 408-983-0271.*	

STUDENT PERSONAL INFORMATION	
Student Name:	Telephone:
Home Address:	
Supervisor Name:	Telephone:
Medical Plan Name:	Policy Number:
Medical Plan Address:	Telephone:
Emergency Contact Name:	Telephone:
Emergency Contact Name:	Telephone:

ACTIVITY INFORMATION	
Date of Activity**: Friday, Oct 17th—Saturday, Oct. 18th, 2014**	Name of Activity: **EDGE October Lock-In, from 7:00PM – 8:00AM.**
Description of Activity: **The October EDGE Lock-In is an overnight activity for Middle School Youth, including: fun games, praise and worship, dinner and breakfast, snacks, prayer, and an all around great time.**	

WAIVER AUTHORIZATION	
FORM MUST BE COMPLETED IN ALL RESPECTS, SIGNED AND DATED TO AUTHORIZE THE WAIVER.	
I HOLD THE PARISH AND DIOCESE OF SAN JOSE HARMLESS FROM ANY CLAIM OF INJURY, SICKNESS, ILLNESS OR DAMAGE THAT MY CHILD MAY SUFFER OR SUSTAIN DURING THE ACTIVITY LISTED ABOVE, WITH EXCEPTION TO INJURY OF DAMAGES ARISING OUT OF THE SOLE NEGLIGENCE OF THE PARISH OR DIOCESE OF SAN JOSE. *I ATTEST THAT MY CHILD IS PHYSICALLY FIT TO PARTICIPATE IN THIS EVENT.* *IN THE EVENT MY CHILD BECOMES ILL OR INJURED, I DO HEREBY CONSENT TO WHATEVER X-RAY, EXAMINATION, MEDICAL OR TREATMENT AND HOSPITAL CARE ARE CONSIDERED NECESSARY IN THE BEST JUDGEMENT OF THE ATTENDING PHYSICAIN AND PERFORMED BY OR UNDER THE SUPERVISOIN OF A MEMBER OF THE MEDICAL STAFF OF THE HOSPITAL FACILITY PROVIDING THE TREATMENT.* *I AM NOT AWARE OF ANY MEDICAL CONDITION WHICH WOULD RENDER IT INAPPROPRIATE FOR MY CHILD TO PARTICIPATE IN ANY SUCH ACTIVITY.*	
Parent Signature:	Date Signed:

PHOTO RELEASE CONSENT	
OCCASIONALLY PICTURES ARE TAKEN OF YOUTH MINISTRY EVENTS AND GATHERINGS. WE WOULD LIKE TO BE ABLE TO USE THESE PHOTOGRAPHS FOR NEWSLETTERS, FLYERS, AND THE PARISH SOCIAL MEDIA & WEB SITE. WE ***WILL NOT USE ANY LAST NAMES*** *IF POSTED. CONCERNS ABOUT PUBLISHED PICTURES SHOULD BE EXPRESSED TO WRITER/ WEBMASTER AND WILL BE PROMPTLY DEALT WITH. I/WE THE PARENT(S) OF THIS STUDENT, AUTHORIZE AND GIVE FULL CONSENT, WITHOUT LIMITATION OR RESERVATION, THE DIOCESE OF SAN JOSE/ ST. THOMAS AQUINAS PARISH-CATHOLIC COMMUNITY OF PALO ALTO TO PUBLISH ANY PHOTOGRAPHS IN WHICH THE ABOVE NAMED STUDENT AAPPEARS WHILE PARTICIPATING IN ANY PROGRAM WITH DIOCESE OF SAN JOSE./ ST. THOMAS AQUINAS PARISH-CATHOLIC COMMUNITY OF PALO ALTO. NO COMPENSATION IS TO BE GIVEN.*	
Parent's Signature :	Date Received:

INTERNAL USE ONLY	
Waiver Received By:	Date Received:

HEALTH AND MEDICAL RELEASE FORM FOR YOUTH

Name: ____ **Date of Birth:** _______________________________________

Address: ____ **Female:** ______ **Male:** ______

City____ **Zip:** _____________________

Parish: ____ **City:** ____

Is this participant in general good health and able to participate in all activities involved in this event? YES______ NO______ (If no, please submit a statement indicating limitations or serious medical conditions.)

Date of most recent physical exam: ________________ Physician: ___________________________________

Address: ____ Phone: _______________________________________

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Are there any known allergies to food or medications that those who work with your young person this week should be aware of? Yes No

If Yes, please explain:

____

Are there any known physical, psychological or emotional limitations that would affect this young person's participation in this event? Yes No

If Yes, please explain:

____

Medicines:

____

If any of the above is yes, please submit a statement of how the child has been treated and with what medication. Any medication not able to be self-administered must be listed.

Does the participant have any special dietary needs? If yes please list on reverse side of form.

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<u>AUTHORIZATION TO CONSENT TO TREATMENT OF MINOR</u>

I/We, the undersigned, parent(s) of ____ a minor, do hereby authorize as agent(s) **[event staff and St. Thomas Aquinas Parish Youth Ministers]** for the undersigned to consent to any X-Ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by and is to be rendered under the general or special

supervision of any physician and surgeon licensed under the provisions of the Medicine Practice Act of the medical staff of any licensed hospital whether such diagnosis of treatment is rendered at the office of said physician or at said hospital.

It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required, but is given to provide authority and power on the part of our for said agent(s) to give specific consent to any and all such diagnosis, treatment or hospital care which the aforementioned physician in the exercise of his/her best judgment may deem advisable.
I agree that in the event my child is injured as a result of his/her participation in this event, including transportation to and from such activity through the negligence (active or passive) of the **[St. Thomas Aquinas Parish]**, or any of any of its agents or employees, recourse for the payment of any resulting hospital, medical or related costs and expenses will first be had against any accident, hospital, medical insurance, or any available benefit plan of mine or my spouse.

I also, give my child permission to self-medicate except for medications which are listed on the back of this form. I understand that any medications so listed will be dispensed by the Director of First Aid for the **[**EDGE October Lock-In: 10/17/14-10/18/14**]**.

This authorization shall remain effective from **[10/17/14—10/18/14].**

Signature of parent(s)/Guardian:
____ Date:
____

Emergency Telephone Number During Event
____ Alternate Telephone
____

Family Health Insurance Co:
____ Policy No.:
____
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(If possible please provide a copy of the insurance card)