**Parent/Guardian Permission & Liability**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, grant permission for my son/daughter, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Parent or Guardian’s Name** **Child’s Name**

to participate in **St. Joseph Church VBS program activities** on  **July 09 – July 13, 2018**. These activities will take place under the guidance and direction of parish employees and/or volunteers from St. Joseph’s Church.

As a parent/guardian, I remain legally responsible for any personal actions taken by son/daughter named above. I agree to hold harmless St. Joseph’s Church, its officers, directors, agents, and the Diocese of Corpus Christi from any liability for illness or death arising from or in connection with my son’s/daughter’s attending the above named event.

**PERMISSION TO PHOTOGRAPH/VIDEO**

\_\_\_\_\_\_\_ **I hereby give** the permission to photograph/film the minor designated above for

Initial lawful purpose associated with St. Joseph Church.

\_\_\_\_\_\_\_ **I DO NOT** **give** permission to photograph/film the minor designated above.

Initial

**Medical Consent & Permission to Treat**

To the best of my knowledge, my child, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ is in good health, and I assume all responsibility for the health of my child. In the event of an emergency, I give permission to transport my child to a hospital for emergency treatment. I wish to be advised prior to any further treatment by the hospital or doctor. If you are unable to reach me, please contact:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to me or my son/daughter: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Alternate Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Carrier: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

My son/daughter is taking medication:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*My son/daughter is allergic to the following: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Does your Child have any special needs?**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Signature Date