

COST: \$200

*Completed forms are due December 15 along with a \$75 non-refundable deposit.

*Final payment is due January 19, 2025. See DCYC info packet for payment plan details.

Parental Consent for Youth to Participate in Activity, Emergency Medical Information, and Release

Participant: _____ (name)

Parents: _____ (names),
for themselves, heirs, executors, and administrators.

Event: _____

Parish/School: _____, located in
_____ (city), Texas, a Texas non-profit corporation,
including its faculty, employees, contractors, clergy, agents, facilitators, and volunteers

Diocese: The Catholic Diocese of Austin, a Texas non-profit corporation, including its employees, contractors, clergy, agents, facilitators, and volunteers.

Transportation Provider: _____

- A. The undersigned represent that they are the parents or legal guardians of *Participant* and have full authority under law to sign this document.
- B. *Parents* grant their permission for *Participant* to enroll and participate in the *Event*.
- C. *Parents* acknowledge and agree that:
- (1) *Participant* and *Parents* voluntarily seek to participate in the *Event*;
 - (2) the *Event* may involve physical activity that involves risk of injury;
 - (3) *Participant* and *Parents* will abide by all policies and rules established for *Event* and instructions of those persons facilitating, organizing, or overseeing the *Event*;
 - (4) *Parents* and *Participant* are responsible for *Participant's* conduct during the *Event* and are responsible for any damages, claims, or other costs caused by *Participant* or incurred as a result *Participant's* conduct; and
 - (5) if *Participant's* conduct is inappropriate, unsafe or detrimental to the *Event*, other participants or other persons, *Parish/School* or the *Diocese* may be suspend or expel *Participant* from the *Event* and future events.
- D. Unless this paragraph is struck and initialed by the undersigned, *Parents* authorize *Parish/School* and the *Diocese* to provide over-the-counter aspirin, pain relievers, cold medicine, and other over-the-counter medications to *Participant* at *Participant's* request if the *Parish/School* or *Diocese* deem it reasonable to do so. The *Parish/School* will make reasonable attempts to notify *Parents* prior to authorizing any such over-the-counter medication.
- E. In the event of an emergency or a situation that is reasonably considered to be an emergency, *Parents* authorize the *Parish/School* and the *Diocese* to seek and authorize emergency medical care to be given to *Participant* (for example, first aid, medication, anesthesia, or surgery). The *Parish/School* will make reasonable attempts to notify *Parents* prior to authorizing any such emergency care.
- F. *Parents* grant *Parish/School* and the *Diocese* permission:
- (1) to photograph and video tape *Participant* during the *Event*; and
 - (2) to use the photographs and video tapes in publications and promotions of the *Parish/School* and the *Diocese*, including but not limited to publications such as websites, newsletters, advertisements, scrapbooks, and yearbooks.

G. To the extent permitted by law, *Parents*, for themselves and for *Participant*, release and agree to indemnify and hold harmless the *Parish/School*, the *Diocese*, and the *Transportation Provider* from any and all liability, claims, demands, and costs which may arise as a result of *Participant's* participation in the *Event* or which is, in any way, related to such participation. This paragraph covers loss under any theory of loss (negligence or otherwise) including but not limited to personal injury or property damage. *Parents* and *Participant* assume all risk of injury or loss to themselves or their property.

Parent/Guardian signature: _____ Date: _____

Parent/Guardian signature: _____ Date: _____

Participant signature: _____ Date: _____

Please provide the following information.

EMERGENCY CONTACT AND INSURANCE INFORMATION

In the event of an emergency contact: _____

Phone: _____

Alternatively, contact: _____

Phone: _____

Participant's Insurance Carrier: _____

Phone: _____

Address: _____

Copy of insurance card must be attached.

Date of last Tetanus Booster: _____

Participant has the following conditions (allergies, medical conditions, etc.): _____

Attach additional sheets if necessary.

Participant is currently taking the following medication: _____

Attach copies of prescription and any instructions related to the medication, including the amount and timing of dosages.

Special instructions or other information: _____

Office Notes