ASCENSION OF OUR LORD

CATHOLIC YOUTH ORGANIZATION

WORLD YOUTH DAY

REGISTRATION

WHEN: SUNDAY, OCTOBER 22ND

DEPART ASCENSION—8:00 AM

RETURN— 5:45 PM

WHERE: MORIAL CONVENTION CENTER

COST: $46.00 (REGISTRATION, LUNCH,

T-SHIRT, & TRANSPORTATION)

Name: _____ School: _____

E-Mail Address: _____

T-Shirt Size (Circle One) Youth Medium Youth Large Adult Small Adult Medium
Adult Large Adult XL Adult XXL

Circle One: Junior High Track (Grades 6-7) High School Track (Grades 8-12)

Lunch must be preordered and paid for before we arrive. Please circle your choice.

1. Hamburger with chips and drink
2. Hot dog with chips and drink
3. Personal pizza with apple and drink

Please have registration form, payment ($46), and medical release forms returned to the parish office by Wednesday, October 11th.

Parent Signature: _____

ARCHDIOCESE OF NEW ORLEANS
MEDICAL INFORMATION AND CONSENT FORM

GENERAL INSTRUCTIONS TO PARENTS/GUARDIANS:

1. Please take care in filling out this form. It provides crucial information for caregivers in the event of illness or medical emergency. Accuracy and thoroughness are encouraged.

2. Sections I, II and V are mandatory. Sections III and IV provide you with treatment options in non-emergency situations.

Participant's name: _____

Birth date: _____ Sex: _____

Parent/Guardian's name _____

Home address: _____
(Street) (City/State) (Zip)

Home phone: _____ Student Cell: _____

Mother Cell: _____ Father Cell: _____

SECTION I. MEDICAL MATTERS

As the parent/legal guardian of the above named child, who is currently associated with _____ Parish. I hereby authorize _____ or his/her assistants to carry out the wishes I have named (herein) in areas of emergency medical treatment and other cases of illness. This authorization inclusively extends from _____, 20__ through _____, 20__. 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.

Signature: _____ Today's Date: _____

SECTION II. EMERGENCY MEDICAL TREATMENT

In the event of an emergency, I hereby give permission to transport my child to a hospital for emergency medical or surgical treatment. I wish to be advised prior to any further treatment by the hospital or doctor. In the event of an emergency, if you are unable to reach me at the numbers listed herein, contact:

Name & relationship: _____

Phone: _____ Family doctor: _____ Phone: _____

Family Health Plan Carrier: _____ Policy #: _____

Signature: _____ Date: _____

SECTION III: OTHER MEDICAL TREATMENT

In the event it comes to the attention of the parish, its officers, directors and agents, chaperones, or representatives associated with the activity that my child becomes ill with symptoms such as headache, vomiting, sore throat, fever, diarrhea, I want to be called collect (with phone charges reversed to myself).

Signature _____ Date: _____

SECTION IV: MEDICATIONS

(SIGN ONLY THOSE OPTIONS THAT ARE APPLICABLE)

- My child is taking medication at present. My child will bring all such medications necessary, and such medications will be well-labeled. Names of medications and concise directions for seeing that the child takes such medications, including dosage and frequency of dosage, are as follows: _____

  _____

  Signature: _____ Date: _____

- I hereby grant permission for non-prescription medication (such as aspirin, throat lozenges, cough syrup) to be given to my child, if deemed appropriate.

  Signature: _____ Date: _____

- NO medication of any type, whether prescription or non-prescription, may be administered to my child unless the situation is life-threatening and emergency treatment is required.

  Signature: _____ Date: _____

SECTION V: MEDICAL INFORMATION

The parish will take reasonable care to see that the following information will be held in confidence.

Allergic reactions (medications, foods, plants, insects, etc.): _____
Immunizations: Date of last tetanus/diphtheria immunization: _____
Does child have a medically prescribed diet? _____
Any physical limitations? _____

Is child subject to chronic homesickness, emotional reactions to new situations, sleepwalking, bed-wetting, fainting? _____

Has child recently been exposed to contagious disease or conditions, such as mumps, measles, chickenpox, etc? _____ If so, date and disease or condition: _____

You should be aware of these special medical conditions of my child: _____

_____

ARCHDIOCESE OF NEW ORLEANS
PARENTAL/GUARDIAN CONSENT FORM AND LIABILITY WAIVER

Participant's name: _____

Birth date: _____ Sex: _____

Parent/Guardian's name: _____

Home address: _____

Home phone : _____ Business phone: _____

I, _____ , grant permission for my child,_____,
to participate in this parish activity that may require transportation to a location away from the parish site. This activity will take place under the guidance and direction of employees and/or volunteers from _____ Parish. A brief description of the activity follows:

Type of event: _____

Location(s): _____

Individual in charge: _____

Duration of activity: _____

Mode of transportation to and from event: _____

As parent and/or legal guardian, I remain legally responsible for any personal actions taken by the above named minor ("participant").

I confirm that there are no necessary changes to the Medical Information Consent form for my child that I previously submitted. If there are any necessary changes, I will complete another Medical Information Consent form.

I agree on behalf of myself, my child named herein, and my spouse, our heirs, successors, and assigns, to indemnify, hold harmless, and defend _____ Parish/School and The Roman Catholic Church of the Archdiocese of New Orleans, their members, directors, officers, employees, agents and representatives associated with the event arising from or in connection with the negligence and/or intentional acts of my child.

Signature: _____ Date: _____