



**Diocese of Laredo
Office of Youth Ministry**

Adult Liability Waiver & Medical Consent

Name: _____ **Birth Date:** _____ **Shirt Size** _____

Address: _____ **City:** _____ **Zip:** _____

Emergency Contact: _____ **Home Phone:** (____) _____

Consent & Liability Waiver

I agree on behalf of myself and my heirs, successors, and assigns, to hold harmless and defend the DIOCESE OF LAREDO, the sponsoring parish (it's pastor, youth minister, and other agents, etc.) or any representatives associated with the scheduled activity or in connection with any illness or injury (including death) or cost of medical treatment and I agree to compensate the DIOCESE OF LAREDO, the sponsoring parish (it's pastor, youth minister, and other agents, etc.) or any representatives associated with the event for reasonable attorney's fees and expenses which they may incur in any action brought against them as a result of such injury or damage.

Signature

Date

Photography Consent

I understand that promotional pictures (individual and group) will be taken during this event. I give permission for pictures to be used for promotional materials (newsletter, newspaper, media, etc.) in highlighting the event.

Signature

Date

MEDICAL CONSENT

Medical Matters

I hereby warrant to the best of my knowledge, to be in good health, and I assume all responsibility for my health.

Emergency Medical Treatment

In the event of any emergency, I hereby give permission to be transported 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 contact:

Name & Relationship _____ Phone: (____) _____

Family Doctor _____ Phone: (____) _____

Medications

I am taking the following medication at the present time.

Medication(s): _____ Dosage: _____
_____ Dosage: _____
_____ Dosage: _____

Administer: _____

_____: I hereby **Do Not Grant Permission** for medication of any type, whether prescription or nonprescription may be administered unless the situation is life threatening and emergency treatment is required. (Please initial)

_____: I hereby **Grant Permission** for nonprescription medication (such as Tylenol, throat lozenges, cough syrup) to be given if deemed advisable. I understand that Aspirin will not be given. (Please initial)

Medical Conditions Information

(Diocesan personnel will take reasonable care to see that the following information will be held in confidence.)

Has had an episode the following or has been diagnosed: Seizures Asthma Diabetic

Allergic reactions to the following (foods, dyes, latex etc) _____

Has had a medical surgery within the last six months? Yes No

Still under doctor's care? Yes No

Has a medically prescribed diet? _____

The following physical limitations? _____

Immunizations current and up to date: Yes No

Date of last tetanus/diphtheria immunization _____

You should also be aware of these special medical conditions: _____

Insurance Information

(Please attach a copy of the Insurance Card, front and back, with this form)

Insurance Carrier: _____

Name of Insured: _____

Insurance ID Number: _____ Insurance Policy Number: _____

I fully understand the foregoing statements and sign this Medical Consent Waiver knowingly, freely, and willingly.

Signature

Date