St. Louis Church, Clarksville - CYM
PERMISSION FORM & RELEASE

Archdiocese of Baltimore
CYM Office – 410-531-6668

Youth Name:	
Parent(s) Name:	*Home Phone:*
Address:	*Cell Number Where Parent Can Be Reached::*
City/State/Zip:	*Parent's Preferred E-mail:*
Youth's Date of Birth:	*Youth's Gender: (Circle one)* *male* *female*

In consideration of the wholesome recreational and learning experience in which my son/daughter will participate, I as parent or guardian of my son/daughter, do hereby agree to allow my son/daughter to accompany the youth ministry/campus ministry group of their parish/school to:

Activity: **PLEASANT VIEW NURSING HOME VISIT** Mount Airy, MD
Date/Time: Saturday, _____ 9:40 am – 12 pm Drop off and pick up are at St. Louis, but please do not show up without first verifying there is a spot.
We spend time with the residents, read Sunday's scripture, and join them in singing.

Email Joe vanderGracht by the Wednesday prior to the date you wish to join. jvander@comcast.net

I/we acknowledge receipt of the attached information sheet describing the planned activities.
In consideration of the opportunity for my son/daughter to participate in the Program, I agree to **RELEASE AND HOLD HARMLESS AND INDEMNIFY** St. Louis Church and parish, the Division of Youth & Young Adult Ministry, the Roman Catholic Bishop of Baltimore and his successors, a Corporate Sole, and all their agents, servants, and employees from any liability, claims, demands and causes of action arising out of or relating to any loss, damage or injury sustained in connection with or arising out of my son/daughter's participation in the Program.

I hereby grant permission to any staff person to obtain medical care from a licensed physician, hospital, or medical clinic for my son/daughter in the event I cannot be reached.

(Check one of the following:)
☐ I am covered by hospitalization and medical insurance under policy # _____ issued by
_____.

☐ I do not have medical coverage and assume responsibility for the cost of hospitalization and medical care for my son/daughter.

I hereby grant permission to any staff person to provide the following over-the-counter drugs to my son/daughter if requested by my son/daughter. (Check all that apply:)

☐ Tylenol ☐ Benadryl ☐ Advil ☐ Sudafed ☐ Midol ☐ Kaopectate ☐ Neosporin

(over)

ADD any other medical information concerning medications, allergies, illness, etc_____

_____

ADD any dietary restrictions: _____

_____

Parents/guardians of participants are advised that photographs or videotape of participants may be used in publications, websites or other materials produced from time to time by the Division of Youth and young Adult Ministry or the Archdiocese of Baltimore. (participants would not be identified, however, without specific written consent.) Parents/guardians who do not wish their child(ren) to be photographed or filmed should so notify the Division in writing. Please note that the Division has no control over the use of photographs or film taken by media that may be covering the event in which your child(ren) participate(s)

_____ _____

Date Parent/Guardian Signature(s)

_____

Child's name

FOR PARENTS:

_____ I can chaperone this activity.

_____ I can drive for this activity (paperwork already on file).

STAND Clearance required for all adult volunteers.