DIOCESE OF STOCKTON
ST. BERNARD'S C.Y.O. PROGRAM
PARENTAL PERMISSION AND HEALTH AUTHORIZATION FORM

YOUTH'S NAME ______________________________ PHONE ______________________________

ADDRESS (Street, City, Zip) ____

SCHOOL __________________________ GRADE __________ BIRTHDATE _________________

PARENT/GUARDIAN'S NAME ___________________________ PHONE _____________________

ADDRESS _____________________________________ WORK PHONE _______________________
(Street, City, Zip)

PERSON(S) (OTHER THAN PARENT) TO NOTIFY IN CASE OF EMERGENCY:

NAME ____ PHONE ____________________________

I/We, the parent, guardians of the above named child hereby give my/our permission for his/her participation in any and all Catholic Youth Association (C.Y.O.) activities. I/We agree to direct my/our child to cooperate and conform with directions and instructions of the C.Y.O. personnel responsible for C.Y.O. activities.

I/We agree that in the event my/our child is injured as a result of his/her participation in C.Y.O. activities, including transportation to and from these activities, whether or not caused by the negligence of the C.Y.O. Program, the Diocese of Stockton, St. Bernard's Parish, or any of its agents or employees, recourse for the payment of any resulting hospital, medical or related costs and expenses will first be had against any accident, hospital or medical insurance, or any available benefit of mine/ours.

In the even we cannot be reached in an emergency, I/we hereby give permission for:

ADULT LEADER ___________________________ ADULT LEADER __________________________

to authorize by his/her signature whatever medical treatment may be considered necessary by the attending physician for my/our child.

PARENT/GUARDIAN'S SIGNATURE ___________________________ DATE _________________

PARENT/GUARDIAN'S SIGNATURE ___________________________ DATE _________________

FAMILY PHYSICAN _______________________________ PHONE _________________________

ADDRESS _________________________________ CITY/ZIP _______________________________

MEDICAL PLAN _________________________________ PLAN NUMBER ____________________

<u>BOTH SIDES OF THIS FORM MUST BE COMPLETED</u>

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PART TWO

MUST BE COMPLETED BY PARENT OR GUARDIAN

IF YOU DO NOT WANT MEDICAL CARE GIVEN TO YOUR CHILD, STATE REASONS: ___________

____

HAVE OR SUBJECT TO (CHECK IF YES):

_________ Asthma _________ Fainting Spells _________ Convulsions _________ Diabetes

_________ Heart Trouble _________ Allergy or reaction to ANY Medication

_________ Sport Restrictions (List) ____

_________ Other (Describe) ____

HAVE DIFFICULTY WITH (CHECK IF YES):

_________ Eyes, Ears, Nose, Throat _________ Digestion

_________ Lungs _________ Menstrual Problems

Any condition now requiring medication? _________ Name of Medication _______________________

Any restriction of activity for medical reasons? _________ Explain ___________________________

____

The above information is accurate to the best of my/our knowledge,

PARENT/GUARDIAN'S SIGNATURE ___________________________ DATE _________________

THE FORM MUST BE AVAILABLE AT ALL CYO RELATED ACTIVITIES

Rev. 9/97