

St. Joan of Arc Catholic Church

Walk for Life-San Francisco, CA | 2017

Participant's Name: _____ Age: _____
 Birth Date: _____ Sex: _____ Grade: _____ T- Shirt Size: _____
 Parents/Guardian's Name: _____
 Address: _____
 City/ZipCode: _____ Email: _____
 Phone 1: _____ Phone 2: _____

I, _____ grant permission for my child, _____
 (Parent/Guardian's Name)
 to participate in the San Francisco Walk for Life Pilgrimage.

Depart Date	From	To	Time
01/18/2017	St. Mary's High School	San Francisco	6:30pm
01/22/2017	San Francisco	St. Mary's High School	9am

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

I agree on behalf of myself, my child named herein, or our heirs, successors, and assigns, to hold harmless, and defend St. Joan of Arc Roman Catholic Church, its officers, directors, employees and agents, and the Diocese of Phoenix, its employees and agents, chaperons, or representatives associated with the event, from any claim arising from or in connection with my child attending the event or in connection with any illness or injury (including death) or cost of medical treatment in connection therewith, and I agree to compensate the parish, its officers, directors and agents, and the Diocese of Phoenix, its employees and agents and chaperons, or representatives associated with the event for reasonable attorney's fees and expenses which may incur in any action brought against them as a result of such injury or damage, unless such claim arises from the negligence of the parish/diocese.

Signature: _____ Date: _____

Medical Matter: 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. *(Of the following statements pertaining to medical matters, sign only those that are applicable.)*

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 above numbers, contact:

Name&Relationship: _____ Phone: _____

Family Doctor: _____ Phone: _____

Family Health Plan Carrier: _____ Policy #: _____

Signature: _____ Date: _____ **Other**

Medical Treatment: In the event it comes to the attention of the parish, its officers, directors and agents, and the Diocese of Phoenix, chaperons, 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.

Initial: _____

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

Initial: _____

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.

Initial: _____

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

Initial: _____

I grant permission to have photos taken of my child for the purpose of parish use. Initial: _____

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

Allergic reactions (medications, food, 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, bedwetting, fainting: _____

Has child recently been exposed to contagious disease or conditions, such as mumps, measles, chicken pox, etc.? If so, list date and disease or condition:

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