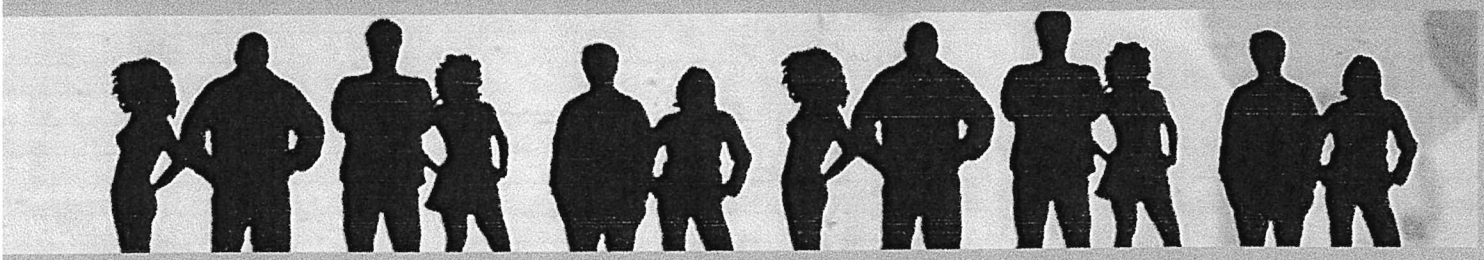
SAN MARTIN DE PORRES CATHOLIC PARISH

Youth Group

LOCK-IN

Friday July 9, 2021

7:00pm - 9:00am (JULY 10)



SPEAKER

FOOD

MUSIC

GAMES

WORSHIP

DOORS WILL BE LOCKED AT 8:00PM.
PERMISSION SLIPS MUST BE TURNED IN PRIOR TO ENTRANCE.

PARISH NAME

San Martin de Porres
Roman Catholic Parish
P.O. Box 65
Sahuarita AZ 85629

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DIOCESE OF TUCSON

FIELD TRIP PARENT REQUEST & ACTIVITY WAIVER AND RELEASE FORM

ACTIVITY: Youth Ministry - "Lock-in"

DATE AND PLACE: July 9-10, 2021 - San Martin de Porres, 15440 S. Santa Rita Rd, Sahuarita AZ

~~TRANSPORTATION WILL BE PROVIDED BY:~~ _____
PRINT PROVIDERS LEGAL NAME

DEPARTURE TIME & DATE: Fri, July 9, 2021 at 7 PM RETURN TIME & DATE Sat July 10, 2021 at 9 AM

I, as a parent or legal guardian, wish for my child _____ to
PRINT PARTICIPATING CHILD'S NAME HERE

participate in the activity described above, and as a condition of my child being allowed to do so, I hereby release and discharge the Roman Catholic Church Diocese of Tucson and Parish Corporations, its constituent organizations, including but not limited to Roman Catholic Parish of San Martin de Porres, the Roman Catholic Church Diocese
PRINT LEGAL NAME OF PARISH HERE

of Tucson, and their officers, agents, employees and volunteers from any and all claims for personal injuries or property damage that my child may suffer as a result of my child's participation in the activity described above including transportation to and from such activity, whether or not such injuries or damage are caused by the negligence (active or passive) of any of the entities or individuals named or described above.

I hereby warrant and represent that my child is physically fit and capable of taking part in such activity. I make this warranty and representation on the basis of advice given to me by a duly licensed medical doctor within the last six months and I know of no change in my child's medical condition since receiving such advice that would affect the opinion of said medical doctor. Should there be a Medical Emergency involving my child, 911 will be called. I agree that any cost or expense related to any emergency will be paid by me, by my insurance company or any benefit plan of mine or child's other parent(s) or legal guardian(s).

I agree that my child will abide by the rules and regulations governing the above described activity and that my child will obey any instructions given by the person or persons having supervision and control over the activity.

I hereby grant permission for my child to be transported by provider listed above.

I hereby authorize the making of photographs, motion pictures, video tapes, recordings, or other memorializing of said event and my child's participation therein and the publication or other use thereof. I and I on behalf of my child, hereby waive any right to compensation therefore or any right that I or my child might otherwise have to limit or control such making or use.

I warrant and represent that I am the parent or legal guardian of the participating child and upon request will produce satisfactory proof of such fact.

By my signature below, I attest that I have read and fully understand this **Field Trip Parent Request & Activity Waiver and Release** document and agree to all its terms:

Signature of Parent or Legal Guardian _____

Print Name of Parent or Legal Guardian _____

Date Signed _____

Street Address _____ City _____ State____ Zip Code_____

Telephone _____ e-mail _____

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HEALTH AND EMERGENCY INFORMATION — San Martin de Porres – Sahuarita AZ

Activity / Event _____ Date of Event _____ Location _____

Participant's Name _____ Sex _____ Age _____ Grade _____

Street Address . _____ Home Telephone _____

_____

Apt # City State Zip

Father's Name _____ Mobile Telephone _____

Mother's Name _____ Mobile Telephone _____

Persons who will care for child if parents cannot be reached:

Name _____ Telephone _____

Name _____ Telephone _____

Family Doctor's Name _____ Telephone _____

Family Dentist's Name _____ Telephone _____

Hospital Preference _____

Health Insurance Plan _____ Policy No. _____

Medical Information _____

_____

_____

Over the Counter Medications may be offered: YES_____ (Tylenol, ibuprofen, Neosporin, Tums and the like) NO_____
Parent Initial Parent Initial

If your child requires self-administered medication/s, please complete Medication Administration on Overnight Events form.

Allergies: _____

AUTHORIZATION TO TREAT A MINOR

I (we) the undersigned parent/ parents or legal guardian of _____ a minor, do hereby authorize and consent to any x-ray examination, anesthetic, medical or surgical diagnosis rendered under the general supervision of any licensed member of the medical staff and emergency room staff, or a dentist licensed and on the staff of any acute general hospital holding a current license to operate a hospital from the State Department of Public Health. It is understood that this authorization is given in advance of any specific diagnosis, treatment of hospital care being required but is given to provide authority and power to render care which the aforementioned physician in the exercise of his best judgment may deem advisable. It is understood that effort shall be made to contact the undersigned prior to rendering treatment to the patient, but that any of the above treatment will not be withheld if the undersigned cannot be reached.

List any restrictions: _____

_____

_____

Date Signature of Father, Mother, or Legal Guardian

_____

Address City State Zip

(Form Print Date 5/9/06)

MEDICATION ADMINISTRATION ON OVERNIGHT EVENTS

When it is absolutely necessary for a youth participant to receive routinely prescribed medication on a field trip, the following procedure shall be employed:

- An envelope shall be provided with the following information:
- Parent/Guardian authorization signature

MEDICATION ADMINISTRATION FOR OVERNIGHT EVENTS Dates of Event: From_____ To_____
TIMES TO BE GIVEN 1._____ 2._____ 3_____ 4._____
Participant's Name
Medication
Dose
Route of Administration
Prescriber
Pharmacy Name & Phone No.
Prescription No.
I agree to provide to the above named participant, at the appointed times, the above-named medication which is contained in this envelope. NAME_____ TITLE_____
Once medication is verified as being in the envelope, the envelope shall be sealed until the medication is due.

PARENT AUTHORIZATION

I authorize the above named person the task of assisting my child in taking the above medication.
I also authorize the above named person to talk with the prescriber or pharmacist should a question come up about the medication.

Medication must be registered with the Religious Education Office or Youth Ministry Office of Parish. It must be in the original container and placed in a sealed envelope. The envelope must be properly labeled with the student's name, prescriber's name, date of prescription, name of medication, dosage, strength, time interval, route of administration, and the date of drug's expiration when appropriate.

_____

Signature of Parent or Guardian Date

_____

Daytime Telephone Evening Telephone Mobile Phone

MAKE TWO COPIES OF COMPLETED FORM. FILE ONE COPY AT PARISH. SECURLY TAPE SECOND COPY TO ENVELOPE CONTAINING MEDICATION. PROPERLY STORE MEDICATION PER DIRECTIONS. PLACE ORIGINAL IN HEALTH INFORMATION BINDER WHICH DRE OR YOUTH MINISTER SHALL MAINTAIN IN HER/HIS POSSESION FOR THE DURATION OF THE EVENT.

(Form Print Date 8/17/06)