

**DIOCESE OF MONTEREY
 PERMISSION WAIVER AND RELEASE & CONSENT FOR TREATMENT FORM
 FOR PARISH/SCHOOL ACTIVITY/EVENT**

To the Parent/legal guardian: This is an agreement releasing the sponsoring parish/school before, during and after the activity/event. This form is also authorization for the adult supervisor to consent to any medical care needed by the minor, if the situation should arise.

This agreement releases the ROMAN CATHOLIC BISHOP OF MONTEREY, CALIFORNIA, A CORPORATION SOLE, also known as the DIOCESE OF MONTEREY which will be referred to as the DIOCESE OF MONTEREY throughout this document, from any claims that the parent/guardian may have against the DIOCESE OF MONTEREY.

**Activity/Event: Holy Cross High School Youth Ministry Program
 Sunday evenings from 6:30 – 8:30 p.m.**

I, _____ (name of parent or legal guardian) parent or legal guardian of
 _____ (name of teen) hereby
 give my permission for my teen to participate in the youth activity named above. I agree to direct my teen to cooperate and conform with directions, instructions and rules established by the chaperones, parish, school or diocesan personnel responsible for the above mentioned youth activity.

In exchange for permitting my teen to participate in the above named activity, to the extent permitted by law, I waive all claims for damages which I may have, or which may hereafter accrue to me or my teen against the DIOCESE OF MONTEREY, for death, personal injuries, and losses or injuries to property, real or personal, caused by or arising out of the above named activity/event. It is further understood and agreed that this agreement, waiver and release is to be binding on my successors, heirs and assigns.

In addition, to the extent permitted by law, I release and discharge in advance the DIOCESE OF MONTEREY and its officers, agents, employees, from any and all liability relating to the above named activity.

I agree and understand that transportation may be provided in such form and at the discretion of the DIOCESE OF MONTEREY.

My teen is physically fit and capable of participation in this event.

I authorize a representative of the DIOCESE OF MONTEREY into whose care the above named minor/s has been entrusted, to consent to and permit any and all necessary medical services for my teen to be rendered to him/her under the general or special supervision and upon the advice of a physician and surgeon licensed under the provisions of the California Medical Practice Act, to consent to and permit any x-ray examination, anesthetic, dental or surgical diagnosis or treatment and hospital care rendered to my teen by a dentist licensed under the provisions of the Dental Practice Act. I hereby give the representative of THE DIOCESE OF MONTEREY permission to use his/her judgment in obtaining medical services. I agree if medical services are required for my teen, THE DIOCESE OF MONTEREY will not be responsible for any medical expenses.

It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required but is given to provide authority and power on the part of the above-mentioned diocesan representative to give specific consent to any and all such diagnosis, treatment or hospital care that the above mentioned physician in the exercise of his/her best judgment may deem advisable.

I hereby authorize any hospital which has provided treatment to the above named minor/s pursuant to the provisions of Family Code section 6910 to surrender physical custody of such minor/s to the diocesan representative upon the completion of treatment. This authorization is given pursuant to Health and Safety Code section 1283.

This authorization shall be in effect during all time that my teen is under the supervision of THE DIOCESE OF MONTEREY for the above mentioned event and shall remain effective until the minor/s returns from the event and is/are no longer under the supervision of the DIOCESE OF MONTEREY.

Signature of Parent/Guardian: _____ Date: _____

Please provide the following:

Teen's Name: _____

Date of Birth: _____ Male Female

Family Doctor: _____ Phone: _____

Family Dentist: _____ Phone: _____

Allergies (foods, drugs, insects, etc.) _____

Medications (name, dosage, reason) _____

Other information (injuries) or special health/physical conditions:

Insurance Information:

Insurance Carrier (Dependent Coverage): _____

Name of Policy Holder: _____ Policy Number: _____

Persons Authorized to Pick-Up (Drive) Teen:

Name: _____

Name: _____

My Teen may walk home from this program.

My Teen may drive him/herself home from this program.

My Teen may ride a bike or skateboard home from this program.

Person(s) to notify in case of an emergency:

Parent(s) Names: _____

Phone Number(s) _____

Other Name: _____

Phone Number(s) _____