

**St. Mary of the Immaculate Conception Church  
Religious Education (PSR) and Youth Ministry Office**

Parent or Guardian Contact Information (in the event of an emergency):

Name(s): \_\_\_\_\_ Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone numbers for Parent or Guardian: (Please list all home, work and cell phone numbers)  
\_\_\_\_\_  
\_\_\_\_\_

**Emergency Authorization and Release for Treatment**

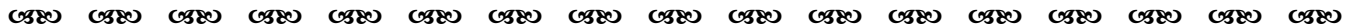
This authorization enables guardians to authorize the provision of emergency treatment for the participant who becomes seriously ill or injured under the authority of St. Mary PSR and/or Youth Ministry when parents/guardians cannot be reached. **This must be signed in order for your child to attend classes/event.**

I, acting as the legal guardian of \_\_\_\_\_ (name of child), grant consent for St. Mary Church to seek medical treatment for him/her in the case of illness or accident from the closest and most appropriate medical practitioner or hospital available. This authorization does not cover major surgery unless the medical opinions of two licensed physicians/dentists concurring in the necessity for such surgery, are obtained for the performance of such surgery.

Any and all information concerning the above named child's history including allergies, medications and physical impairments, has been reported in these forms. In the event of an emergency, I authorize St. Mary Church to share the completed information with persons related to the treatment of the above named program member.

I understand that St. Mary Church will make reasonable efforts to contact me or the listed emergency contacts in the case that medical attention will be necessary.

X \_\_\_\_\_  
Parent's/Guardian's signature (or participant if over 18) Date



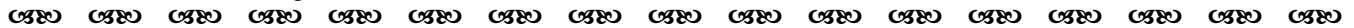
**Medical Information**

Health Insurance Carrier: \_\_\_\_\_ Name of Policyholder: \_\_\_\_\_  
Member Number: \_\_\_\_\_ Group Number: \_\_\_\_\_ Child's Birth Date: \_\_\_\_\_

The following includes any allergies, **especially food allergies**, my child may have, any medication my child may be taking, and any other facts to which a physician or dentist should be alerted: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**I fully understand what is involved in this experience and the foregoing form, and I understand I have the opportunity to call the Religious Education and Youth Ministry Office (330-264-5838) with any questions I may have.**

X \_\_\_\_\_  
Parent's/Guardian's signature Date



**Photograph/Videotape Release**

I/We hereby give consent to photograph or videotape aforesaid participant and without limitation to use such photographs or videotapes and stories in connection with any work of St. Mary Religious Education (PSR) and/or Youth Ministry without consideration of any kind, and I do hereby release St. Mary Religious Education and Youth Ministry from any claims whatsoever which may arise in said regard.

X \_\_\_\_\_  
Parent's/Guardian's **signature** or Participant's **signature** if 18 years or older Date

\_\_\_\_\_  
Print Name Date