

PARISH/ SCHOOL _____

County _____

Archdiocese of Newark CYO Athletics

PARENTAL/GUARDIAN CONSENT FORM AND LIABILITY WAIVER

PARTICIPANT'S NAME: _____ BIRTH DATE: _____ Grade _____

PARENT/GUARDIAN'S NAME: _____

HOME ADDRESS: _____ E-mail Address _____

HOME PHONE: _____ EMERGENCY PHONE _____

I, (name of parent or guardian) _____, grant permission for my child (name of child) _____ to participate in the Archdiocese of Newark CYO Youth Ministry Athletic Program of

(PLEASE CIRCLE) Volleyball Basketball for the 2018-2019 Academic year.

For value received, I agree on behalf of myself, my child's other parent if known or living

(name of parent) _____ my child named herein, or our heirs, successors, and assigns, to hold harmless and defend the Archdiocese of Newark, Youth and Young Adult Ministry ("OYYAM"), its officers, directors, and agents, and all parishes within the archdiocese, and the officers, agents, representatives, volunteers and employees of either the archdiocese or any parish thereof, and chaperones or representatives associated with the "Program" with respect to any and all actions, claims or demands that may be made or brought against OYYAM, its officers, directors and agents, and the Archdiocese of Newark and all parishes within the archdiocese, and the officers, agents, representatives, volunteers and employees of either the archdiocese or any parish thereof, and chaperones or representatives associated with the "Program", arising from or in connection therewith, and I agree to compensate OYYAM, its officers, directors and agents, and the Archdiocese of Newark and all parishes within the archdiocese, and the officers, agents, representatives, volunteers and employees of either the archdiocese or any parish thereof, and chaperones or representatives associated with the "Program" for reasonable attorney's fees and expenses arising in connection therewith.

MEDICAL MATTERS: 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 in accordance with your wishes.**

Emergency Medical Treatment: In the event of an emergency, I hereby give permission to OYYAM, its officers, directors and agents, and the Archdiocese of Newark and all parishes within the archdiocese, and the officers, agents, representatives, volunteers and employees of either the archdiocese or any parish thereof, and chaperones or representatives associated with the "Program" 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 and RELATIONSHIP: _____

Telephone: _(_____) _____

FAMILY DOCTOR: _____

Telephone: _(_____) _____

FAMILY HEALTH PLAN CARRIER: _____

Policy Number: _____

Group Number _____

(1) Signature: _____ **Date:** _____

PLEASE TURN OVER AND COMPLETE BACK OF THIS FORM

Other Medical Treatment: In the event it comes to the attention of OYYAM, its officers, directors and agents, and the Archdiocese of Newark and all parishes within the archdiocese, and the officers, agents, representatives, volunteers and employees of either the archdiocese or any parish thereof, and chaperones or representatives associated with the "Program", that my child becomes ill with symptoms such as headache, vomiting, sore throat, fever, diarrhea, I want to be called REGARDLESS of the Time, etc.

(2) **Signature:** _____ **Date:** _____

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

(3) **Signature:** _____ **Date:** _____

Please sign **ONLY** if you have listed medications above in this part.

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

- Allergic reactions (medications, foods, 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 condition, such as mumps, measles, chicken pox, etc.? _____
- If so, date and disease or condition: _____
- You should also be aware of these special medical conditions of my child _____

I fully understand the consequences of the foregoing statements and sign this **PARENTAL/GUARDIAN CONSENT FORM AND LIABILITY WAIVER** knowingly, freely, and willingly. **(Your signature must appear below or your child will not be permitted to attend the "Program")**

(4) **Signature:** _____ **Date:** _____

Mom's Cell Number _____

Mom's Email Address _____

Dad's Cell Number _____

Dad's Email Address _____

Parent or guardian **must** sign lines numbered 1 and 4. If your parish requires notarization of this form, please have notarized.