

**VACATION BIBLE SCHOOL 2010: Permission for Care**

(A form is required for each individual on the premises – infant through adult.)

**Name:** \_\_\_\_\_

**Name of Parent/Legal Guardian (if under 18):** \_\_\_\_\_

**Address:** \_\_\_\_\_

**City/State/Zip:** \_\_\_\_\_

**Phone: Home** \_\_\_\_\_ **Work** \_\_\_\_\_ **Mobile** \_\_\_\_\_

**Emergency Contact Person:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

**Phone: Home** \_\_\_\_\_ **Work** \_\_\_\_\_ **Mobile** \_\_\_\_\_

**Date of Birth (if under 18):** \_\_\_\_\_ **Date of last Tetanus Booster:** \_\_\_\_\_

**List food allergies or write N/A if none (Continue on back if needed):**

\_\_\_\_\_

**List medicine allergies or write N/A if none (Continue on back if needed):**

\_\_\_\_\_

**Any other medical problems that should be noted (Continue on back if needed):**

\_\_\_\_\_

**Current Medications (Continue on back if needed.):**

\_\_\_\_\_

**Family Physician Name & Phone:** \_\_\_\_\_

**Insurance Carrier & Policy Number:** \_\_\_\_\_

As the parent/legal guardian of \_\_\_\_\_, permission is hereby given for my child to attend Vacation Bible School from **July 19 – 23, 2010 at Queen of Apostles' School in Alexandria beginning at 8:45am and ending with pick-up at Noon.** I understand and acknowledge that my child will be participating in activities that are low impact; however, accidents may still happen. These activities include field day activities, scavenger hunts, and relay races. I agree to indemnify the Parish, Volunteers, and the Diocese of Arlington for any costs or expenses arising out of my child's participation in the activities including the cost of any medical care given to my child.

**I further give my consent to** that in my absence the above-named minor may be admitted to any hospital or medical facility for diagnosis and treatment. I request and authorize physicians, dentists, and staff, duly licensed as Doctors of Medicine or Doctors of Dentistry or other such licensed technicians or nurses, to perform any diagnostic procedures, treatment procedures, operative procedures and x-ray treatment of the above minor. I have not been given a guarantee as to the results of examination or treatment. I authorize the hospital or medical facility to dispose of any specimen or tissue taken from the above-named minor.

**Signature of Parent:** \_\_\_\_\_ **Date** \_\_\_\_\_

**OR**

Permissions, indemnifications, consents, and authorizations listed above are given for my personal medical care.

**Signature of adult:** \_\_\_\_\_ **Date:** \_\_\_\_\_