**ALPHA OMEGA**
ST. MARY OF VERNON YOUTH MINISTRY
236 U.S. HWY 45
INDIAN CREEK, IL 60061
847-362-1021

TEEN PERMISSION FORM -- INDIVIDUAL EVENT

I hereby give permission for my teen _____

to participate in the **All-Night Lock-In** to be held from **Friday to Saturday, February 1st to February 2nd**

I understand that this event will take place at the Enchanted Castle in Lombard, Illinois, that it will be

chaperoned by adult leaders, and that participation in this event will include transportation by bus.

I hereby release and indemnify the staff and volunteers of St. Mary of Vernon, Indian Creek, Illinois and the Catholic Bishop of Chicago, a corporation sole, from any and all liability arising from claims of any kind or nature whatsoever from my teen's participation in this event.

I understand that my son/daughter will be asked to abide by the rules and respect the property of others. I realize that any serious misconduct will result in my being called to pick him/her up immediately.

I grant permission for the administration of first aid by the people of St. Mary of Vernon in charge of this event as their judgment deems advisable, and to make the necessary referrals to qualified physicians for treatment of illness or accidents of a more serious nature.

****Is the year-long Parental Consent/Medical Form* on file in the YM office for your teen? ____**
**If not, then that form must also be filled out and turned in.**

*If "yes" please list any changes to this form below, along with any medical allergies, medications being taken, medical problems, and/or physical activities your teen cannot take part in:

Signature of Parent/Guardian: _____Date:_____

Home Number: _____ Cell Number: _____

## The $50, Permission Form, Medical Consent Form must be returned together to the PREP, Main, or Youth Ministry Office by: Monday, Jan. 28th

**(Checks can be made payable to "St. Mary of Vernon")**

Good through July '19

# PARENTAL CONSENT / STUDENT MEDICAL FORM

## June 1, 2018 through July 31, 2019

Student's Name:_____ D.O.B.:_____ Grade: _____

Student's Cell*: _____ Home Phone: _____

* Willing to receive texts? ☐ Yes ☐ No

Address: _____ City: _____

Student email: _____ School: _____

In case of an accident, I (we) authorize permission for the administration of first aid to my (our) student by those in charge as their judgment deems advisable, and to make the necessary referrals to qualified physicians for treatment of illness or accidents of a more serious nature. I (we) understand that I (we) will be promptly notified in the event of any medical emergency except when the delay in such communication would endanger life. In the event that I (we) cannot be reached I (we) give permission to the physician selected by the adult staff to hospitalize, secure proper treatment for, and to consent to any x-ray examination, anesthetic, medical, surgical, or dental diagnosis or treatment, and hospital care, to be rendered to the minor under supervision and on the advice of any physician or dentist licensed under the provisions of the Medical Practice Act on the medical staff of a licensed hospital, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital.

I (we) will be liable and agree to pay all costs and expenses incurred in connection with such medical and dental service rendered to my (our) child pursuant to this authorization. **This release form covers the time span from June 1, 2018 through July 31, 2019.**

I understand that St. Mary of Vernon Youth Ministry may contact my child by phone/cell phone, texting, email, and/or Social Media.

I understand that photos and/or videos of my child may be taken periodically and that they may be posted in the bulletin, on the St. Mary of Vernon Parish website (with name omitted) [www.maryofvernon.org], and/or Parish social media pages. ☐ I consent ☐ I do not consent

**Parent(s)/Guardian** _____

Cell Phone No.1 _____ Cell Phone No. 2 _____

Parent(s) Email _____

**<u>Other Contact in case of emergency</u>:**

Name _____ Phone No. _____

**Authorized Physician** _____ Phone No. _____

**<u>Insurance Information:</u>**

Insurance Co. _____

Policy No. _____ Identification No. _____

**Please List any allergies and/or other medical conditions you think we should know about:**

**Signature of Parent/Guardian** _____ Date: _____