

PERMISSION FORM

Name of Event: 2009 Mission Trip – Ferdinand, Indiana and Surrounding Community

Dates of Event: June 14, 2009 to June 19, 2009

Activities involved: We will join in service projects within the community such as yard work, painting, cleaning, working with the elderly, assisting with vacation bible school, working in the Sisters of St. Benedict bakery, leveling headstones, and/or animals are common.

Lodging at: Sisters of St. Benedict Monastery Immaculate Conception
802 E. 10th Street
Ferdinand, Indiana 47532
812-367-1411

Transportation: Private Vehicles

Supervised by: Chaperones from St. Joseph's in Marion; (Primary Contact Tom Kadela), Holy Spirit in Carterville, Gallatin County Cluster, and Millstadt Catholic Church.

If you wish your child to participate in the above described event, please read, complete, sign, and return the following statement of consent and release of liability.

I request that my child be allowed to participate in the 2009 Mission Trip to Ferdinand, Indiana and surrounding community as described above. I grant my permission for

_____ to attend this event and release and agree to indemnify and hold harmless *Holy Spirit in Carterville; St. Joseph in Marion; Millstadt Churches* and attending *Gallatin County Churches* , and all persons connected with this event from any liability, claims, or damages for personal injury, or property loss or damage that may result during the event. My signature also gives authorization to the above-named entity to secure treatment for my child by emergency personnel in the event of an accident after reasonable effort has been made to reach me.

Signature of Parent/Guardian.

Date

Print parent/guardian name

(____) _____
Phone

Address

City, State, Zip

If you have medical insurance, your carrier will be billed for medical charges in the case of illness or injury while your child is participating in the activity. Do you have health insurance? _____

Name of Primary Insured _____
Insured Social Security # _____ - _____ - _____
Relationship to Participant _____
Insurance Carrier _____ Policy or Group # _____
Family Physician _____
Physician Phone Number: Daytime (____) _____ Evening (____) _____

Please include a copy (front and back) of your insurance card.

IN CASE OF MEDICAL EMERGENCY, I understand that when medically feasible, every effort will be made to reach the parent/guardian listed on this form, but in the event one cannot be reached or if it is not medically feasible to contact one, I hereby give permission to the physician or dentist selected by the adult leaders to hospitalize, secure medical treatment and/or to order an injection, anesthesia, or surgery for my child as deemed necessary for treatment.

I understand that all reasonable safety precautions will be taken at all times by Holy Spirit & St. Joseph's Youth Ministry Commissions and it's agents during the events and activities. I understand the possibility of unforeseen hazards and know the inherent possibility of risk. I agree not to hold the Holy Spirit & St. Joseph's Youth Ministry Commissions, its leaders, employees, and volunteer staff liable for damages, losses, diseases, or injuries incurred by the subject of this form.

Parent(s)/Guardian Signature _____ Date _____
_____ Date _____
If two custodial parents, both must sign

Print name of Parent Guardian _____ Date _____
Address _____
City, State, Zip _____
Phone Number: Home (____) _____ Work (____) _____
Cell (____) _____

Signature of Participant if over 18 years of age:
_____ Date _____

If consent is needed for non-emergency treatment of for other matters, and I cannot be reached, the following person is authorized to act on my behalf:

Name (please print) _____
Address _____
City, State, Zip _____
Relationship _____ Phone # (____) _____
Signature of Parent/Guardian _____

Please be advised that it is the responsibility of the parent/guardian to keep the adult leaders informed of any changes in health status for the named participant.

HEALTH HISTORY (Please Print)

Participant Name _____ Date of Birth ____/____/____
Age ____ Gender _____ Height _____ Weight _____ Social Security # _____-_____-_____
Address _____
City _____ State _____ Zip Code _____
Phone # (____) _____ Religious Preference _____
Date of last doctor's exam ____/____/____ Last Tetanus ____/____/____

Immunization for:

- | | | | | |
|-------------------------------------------------------|--------------------------------------|-----------------------------------------|------------------------------------|--------------------------------------|
| <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Measles | <input type="checkbox"/> Poison Ivy | <input type="checkbox"/> Polio | <input type="checkbox"/> Chicken Pox |
| <input type="checkbox"/> Tetanus | <input type="checkbox"/> Small Pox | <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Pneumonia | |
| <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Allergy Shots | | |
| <input type="checkbox"/> Other (please explain) _____ | | | | |

Are immunizations up-to-date? _____

ILLNESSES & INJURIES: (include date of occurrence or diagnosis)

- | | | |
|-------------------------------------------------------|----------------------------------------|-----------------------------------------------------|
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Asthma | <input type="checkbox"/> Bleeding/Clotting Disorder |
| <input type="checkbox"/> Bulimia | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Chronic Ear Infection |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Hay Fever |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Migraines | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Sinus Trouble | |
| <input type="checkbox"/> Other (please explain) _____ | | |

ALLERGIES: (Specify)

- Animals _____
 Medicine/Drugs _____
 Food _____
 Hay Fever/Pollen/Plants _____
 Insect Stings _____
 Other _____

ARE YOU TAKING ANY MEDICATION; EITHER PRESCRIPTION OR OVER-THE-COUNTER ON A REGULAR BASIS? Yes No

If yes, please list all medications followed by the condition being treated with said medication:

OTHER HEALTH CONDITIONS:

- Fainting Nosebleeds Special Diet (explain) _____
 Wears contact lenses or glasses Sleepwalking

ANY MAJOR ILLNESSES OR SURGERIES DURING THE PAST 12 MONTHS? _____

If yes, please explain _____

If any of the above is checked, please give details (i.e. warning signs of an asthma attack). Please include any other information about the above-named person that might be useful in case of an emergency:

