Shrine of St. Padre Pio Catholic Church

PARENT/GUARDIAN PERMISSION AND LIABILITY WAIVER

I, ____ grant permission for my son/daughter,

____ to participate in Theology of the Body at the Shrine of St. Padre Pio.

This activity will take place under the guidance and direction of parish employees and/or volunteers from Shrine of St. Padre Pio Catholic Church. I, also consent to the use by of any videotapes, photographs, slide, audiotapes, or any other visual or audio reproduction with which I may appear. I understand that these materials are being use for the promotion of Shrine of St. Padre Pio Catholic Church. Such promotional activities extend to recruitment, fund-raising, advocacy etc.

This activity will take place under the guidance and direction of parish employees and/or volunteers from St. Padre Pio

As parent/legal guardian, I remain legally responsible for any personal action taken by my son/daughter named above.

I agree on behalf of myself, my son/daughter named herein, our heirs, successors, and assigns to hold harmless and defend Shrine of St. Padre Pio Catholic Church its officers, directors, agents, and Archdiocese of San Antonio from any liability for illness, injury or death arising for or in connection with my son's/daughter's attending the above named event, I release the staff, volunteers, etc. from any liability connected with the use of my picture or voice recordings as a part of any of the above or similar activities, and I agree to compensate the parish, its officers, directors and agents, and the Archdiocese of San Antonio, or representatives associated with the event for reasonable attorney's fees and expenses arising in connection therewith.

MEDICAL CONSENT AND PERMISSION TO TREAT

I am giving medical permission and consent to treat.

To the best of my knowledge, my child is in good health, and I assume all responsibility for the health of my child.

In the event of an emergency, I give permission to transport my child to a hospital for emergency treatment.

I wish to be advised prior to any further treatment by the hospital or doctor.

If you are unable to reach me, please contact:

Emergency Contact: ____

Relationship to me or my son/daughter: ______________________________

Home Phone: ______________________ Cell Phone: ______________________

Please include a photocopy of your Insurance card, front and back. ONLY IF NOT ON FILE

Insurance Carrier: __________________________ Policy Number: __________________

My son/daughter is allergic to the following: ______________________________

My son/daughter has the following limitations: ______________________________

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Parent/Guardian Name (Print)

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Signature **Date**