# Parent/Guardian Permission Slip
# Medical Questionnaire /Medical Authorization/Indemnity Agreement

**Sponsor of Program/Activity:** **Risen Savior Catholic Community**
**Program/Activity** **Children's Faith Formation Program**
**Date of Program/Activity:** **September 2019 – April 2020**
**Place of Program/Activity:** **Risen Savior Catholic Community campus**

The undersigned, as parent or legal guardian of _____, does hereby give permission for the above named individual to attend the described program/activity. As parent and/or legal guardian of the above named individual, I remain legally responsible for any personal actions taken by the above named minor ("participant").

I agree on behalf of myself, my child named herein, or our heirs, successors, and assigns, to hold harmless and defend Risen Savior Catholic Community, its officers, directors, employees and agents, and the Archdiocese of Santa Fe, its employees and agents, chaperones, or representatives associated with the event, from any claim arising from or in connection with my child attending the event or in connection with any illness or injury (including death) or cost of medical treatment in connection therewith, and I agree to compensate the parish, its officers, directors and agents, and the Archdiocese of Santa Fe, its employees and agents and chaperones, or representative associated with the event for reasonable attorneys' fees and expenses which may incur in any action brought against them as a result of such injury or damage, unless such claim arises from the negligence of the parish or the Archdiocese of Santa Fe.

It is possible that at times leadership team members may take photographs or videos of events in which your child may be participating. By signing this you acknowledge that your child may be photographed during the course of their participation and those photographs may be used/published for church purposes.

I hereby authorize the Supervisor of the activity or his/her designee to act in my behalf to authorize such medical attention, surgery, or other health care services, as may be recommended in an emergency situation while participating in the activity. If the below named physician cannot be reached, I hereby authorize any licensed physician or medical center to treat my child.

## Medical Questionnaire

Parent/Guardian Name(s): _____

Parent/Guardian Phone: _____ _____ _____
Home Work Cell

In case of an emergency, a parent/guardian is contacted first. If unable to reach parent/guardian, please contact:

First ~ Name: _____ Phone: _____ Relationship: _____

Second ~ Name: _____ Phone: _____ Relationship: _____

Name of Physician _____ Phone _____ Hospital Preference:_____

Does your child have any physical, mental, or emotional concerns that we need to be aware of? If yes, explain.

_____

Is your child allergic to any food or medicines? No _____ Yes _____ If yes, what: _____

Does this child have any special needs? No _____ Yes _____ If yes, what: _____

Does this child have difficulties with any of the following? (If so, please explain):

☐ Asthma ☐ ADD ☐ Autism ☐ Hyperactivity ☐ Eyesight ☐ Reading ☐ Writing ☐ Speaking ☐ Hearing

☐ Other notes: _____

Please list any medications your child is taking: _____

~~I hereby authorize the Supervisor of the activity or his/her designee to administer the following medication to my child according to the instructions described here:~~
~~Medication: _____~~
~~Directions: _____~~
~~If the medication is prescribed by a doctor, the prescription in its original container will be provided to the Supervisor of the activity.~~

*I have read and completed the above information and certify that I have disclosed all medical information regarding my child.*

Signature _____ Date _____
Parent/Guardian