

**HOLY NAME OF JESUS PARISH  
RELIGIOUS EDUCATION PROGRAM**

**Parental Permission and Health Authorization Form**

**Child's/Youth's Name:** \_\_\_\_\_ **Phone** \_\_\_\_\_

Address [Street, City, Zip] \_\_\_\_\_

School \_\_\_\_\_ Grade \_\_\_\_\_ Birthdate: \_\_\_\_\_

**Parent/Guardian Name:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

Address \_\_\_\_\_ **Work Phone:** \_\_\_\_\_

Person(s) other than parent to notify in case of emergency:

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

I/We, the parent(s)/guardian(s) of the above named child hereby give my/our permission for his/her participation in and all Religious Education activities. I/we agree to direct my/our/ child to cooperate and conform with directions and instructions of Religious Education personnel responsible for Religious Education activities.

I/We agree that in the event my/our child is injured as a result of his/her participation in Religious Education activities, including transportation to and from these activities, whether or not caused by the negligence of the Parish/School Religious Education Program or any of its agents or employees, recourse for payment of any resulting hospital, medical or related costs or expenses will first be had against any accident, hospital or medical insurance, or any available benefit of mine/ours.

In the event we cannot be reached in an emergency, I/We hereby give permission for:

ADULT LEADER \_\_\_\_\_ ADULT LEADER \_\_\_\_\_

to authorize by his/her signature whatever medical treatment may be considered necessary by the attending physician for my/our child.

PARENT/GUARDIAN SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**BOTH SIDES OF THIS FORM MUST BE COMPLETED**

**MUST BE COMPLETED BY PARENT OR GUARDIAN**

HOSPITAL \_\_\_\_\_

FAMILY PHYSICIAN \_\_\_\_\_ PHONE \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY/ZIP \_\_\_\_\_

MEDICAL PLAN \_\_\_\_\_ PLAN # \_\_\_\_\_

IF YOU DO NOT WANT MEDICAL CARE GIVEN TO YOUR CHILD, STATE REASONS:

\_\_\_\_\_  
\_\_\_\_\_

HAVE OR SUBJECT TO: [CHECK IF YES]

\_\_\_\_\_ Asthma \_\_\_\_\_ Fainting spells \_\_\_\_\_ Convulsions \_\_\_\_\_ Diabetes \_\_\_\_\_ Heart trouble

\_\_\_\_\_ Allergy or reaction to ANY Medication \_\_\_\_\_ Sport Restrictions – List:

\_\_\_\_\_  
\_\_\_\_\_ Other – Describe: \_\_\_\_\_

Have difficulty with [check if yes]:

\_\_\_\_\_ Eyes \_\_\_\_\_ Ears \_\_\_\_\_ Nose \_\_\_\_\_ Throat \_\_\_\_\_ Digestion \_\_\_\_\_ Lungs  
\_\_\_\_\_ Menstrual problems

Any condition now requiring medication? \_\_\_\_\_ Name(s) of medications: \_\_\_\_\_

\_\_\_\_\_  
Any restriction of activity for medical reasons? \_\_\_\_\_ Explain: \_\_\_\_\_

**THIS FORM MUST BE AVAILABLE AT ALL RELIGIOUS EDUCATION PROGRAM  
ACTIVITIES**

