

**Individual YOUTH MEDICAL RELEASE FORM** Due Date: \_\_\_\_\_

As the parent/legal guardian of \_\_\_\_\_ (please print legibly), permission is hereby given for my child to attend the Steubenville Youth Conference on July 9-11, 2010 at Franciscan University in Steubenville, Ohio. The meeting time will be \_\_\_\_\_ (time) at \_\_\_\_\_ (location) and the pickup time will be \_\_\_\_\_ (time) at \_\_\_\_\_ (location).

I hereby understand and acknowledge that participation in the activities involves inherent risks of injury to my child including risks associated with transportation by motor vehicle. I voluntarily and without reservation and on behalf of myself, my heirs, and my estate, hereby indemnify, defend and hold harmless the Diocesan employees, volunteers, participating parishes, Most Reverend Paul S. Loverde, Bishop, his successors, and the Diocese of Arlington from any and all liability, loss damages, costs, or expenses which are sustained, incurred, or required arising out of my actions in the course of the entire Steubenville trip, including the cost of any medical care given to me or any expenses or fees incurred in any lawsuit arising as a result of any damage or injuries caused by me in the course of my participation in the activity.

*I further give my consent that in my absence and ability to be reached by telephone the above-named minor be admitted to any hospital or medical facility for diagnosis and treatment. I request and authorize physicians, dentists, and staff, duly licensed as Doctors of Medicine or Doctors of Dentistry or other such licensed technicians or nurses, to perform any diagnostic procedures, treatment procedures, operative procedures and x-ray treatment on the above minor. I have not been given a guarantee as to the results of examination or treatment.*

*I recognize and acknowledge there is no accident coverage nor is there any medical payments coverage available to me in order to compensate me for expenses I incur from deductibles, co-payments, prescription drugs, or medical services not covered through my own health insurance provider(s) for any injury my child sustains as a result of the Steubenville Youth Conference.. I agree that any medical coverage(s) I have will be primary and under no circumstance will I seek any contribution from the Diocese, or their insurer, for any medical expenses. Also, I authorize the Diocese of Arlington to use my child's picture or video recording for educational and/or marketing purposes. Parents /guardians who do not wish their child to be photographed or filmed should notify the Office of Youth Ministry in writing.*

\_\_\_\_\_  
Date of Birth Date of last Tetanus Booster

\_\_\_\_\_  
Known allergies including any allergies to medicine (Continue on back of form if needed)

\_\_\_\_\_  
Any other medical problems which should be noted (Continue on back of form if needed)

\_\_\_\_\_  
Name of Parent/Guardian

\_\_\_\_\_  
Address City/State/Zip

\_\_\_\_\_  
Phone Home Work Mobile

\_\_\_\_\_  
Person responsible for charges (if different from above)

\_\_\_\_\_  
Address City/State/Zip

\_\_\_\_\_  
Phone Home Work Mobile

\_\_\_\_\_  
Person to notify if parent/guardian is unavailable

\_\_\_\_\_  
Phone Home Work Mobile

\_\_\_\_\_  
Family Physician Phone

\_\_\_\_\_  
Signature of Parent Date

\_\_\_\_\_  
Signature of Stakeholder Date

**Please tape a Xeroxed copy of both sides of your insurance card HERE.**