Youth Registration/Medical Information

Name: _____ Birth Date:_____

Name of Parents/ Guardians:_____

Address:_____

E-mail Address:_____

Home Phone:_____ Cell Phone:_____

Person to Notify if parent/guardian is unavailable:_____

Home Phone:_____ Cell Phone:_____

Family Physician:_____ Phone:_____

Insurance Carrier & Policy Number:_____

Allergies:_____

Any other medical conditions:_____

I understand and acknowledge that participation in the activities involves inherent risks of injury to my child. I agree to indemnify the Parish, Youth Ministers, Volunteers, and the Diocese of Arlington for any costs or expenses arising out of my child's participation in the activities including the cost of any medical care given my child or any expenses or fees incurred in any lawsuit arising as a result of any damage or injuries caused by my child in the course of his/ her participation in the activity.I further give my consent to that in my absence 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 of the above minor. I have not been given a guarantee as to the results of examination or treatment. I authorize the hospital or medical facility to dispose of any specimen or tissue taken from the above-named minor.

Parent Signature:_____ Date:_____