St. John Paul II Catholic Parish
Athletics Annual Permission Form for the 2019-2020 School Year

Student's Information:

Full Legal Name: _____ Preferred Nickname: _____

Date of Birth: _____ Grade/School: _____ Parish: _____

Mailing Address: _____

City, State, Zip: _____

Parents' Information:

Mother's Name: _____ Email: _____

Cell Phone: _____ Can we send text messages to this number? YES or NO

Father's Name: _____ Email: _____

Cell Phone: _____ Can we send text messages to this number? YES or NO

Permission and Release:

As parent or guardian of the above named child, I hereby request that my child be allowed to participate in and/or travel with the St. John Paul II Catholic Church Athletics Program to all practices and games in the local area as well as outside of the state of Indiana.

I hereby release the Archdiocese of Indianapolis, New Albany Deanery Catholic Youth Ministries, and St. John Paul II Catholic Church as well as associated staff and adult volunteer leaders from any claim, loss, cost, damage or expense arising out of any accident or other occurrence causing injury to any person or property during these events or activities.

Should it be necessary for my child to return home due to medical reasons, disciplinary action, or otherwise, I hereby assume all transportation costs.

Signature: _____ Date: _____

Acknowledgement of St. John Paul II Athletic Operation Policies and Expectations:

I have read and understand Sections I (Student Athlete) and II (Parent/Guardian) of the St. John Paul II Athletic Operation Policies and Expectations.

Signature: _____ Date: _____

If you have any questions, please contact the Athletic Committee:
More information and contact information for Athletic Committee members is available at www.stjohnpaulathletics.org

Be sure to complete the annual medical release and emergency information form on the back of this page.

St. John Paul II Catholic Parish
Athletics Annual Medical Release for the 2019-2020 School Year
Emergency Contact and Medical Information

IDENTIFYING INFORMATION:			**EMERGENCY CONTACT INFORMATION:**		
Full Legal Name of Child:			***In the case of emergency or serious illness of my minor child, please attempt contact in the order listed below:***		
Birthdate:	Gender:		**Call 1st:**	Name:	Home/Work Phone:
Parent (Guardian) Names:				Relationship:	Cell: Phone:
Address Street:			**Call 2nd:**	Name:	Home/Work: Phone:
Address Apartment No./Other:				Relationship:	Cell: Phone:
Address City:	State:	ZIP:	**Call 3rd:**	Name:	Home/Work: Phone:
Home Phone:	Parent E-mail:			Relationship:	Cell: Phone:
Child lives with: ☐ Mother and Father ☐ Mother ☐Father ☐ Grandparent(s) ☐ Guardian			Local Hospital of Choice:		
Who is the Custodial Parent (if applicable)?	☐ Custody Papers on file?		Physician of Choice:	Phone:	
Siblings attending this parish athletics program:			**HEALTH INSURANCE INFORMATION:**		
Adults authorized to pick up my child:	Name:	Phone Number:	Company:	Co. Phone:	
			Policy Holder:	Group No.:	
			Holder ID No.:	Plan No.:	
			Policy No.:	Patient (Child) ID No:	

MEDICAL INFORMATION:

Child's Medical Conditions	Please list below any medical conditions your child has such as chronic or serious illness; severe allergies or sensitivities including, but not limited to: food, medicine, insects, or heat; asthma; diabetes, heart condition; respiratory problems; seizures, urinary problems; hemophilia; frequent hospitalizations; vision or hearing difficulties, physical or mental limitations, etc.	**Medications Taken Regularly by Child**	Please list below any medications, treatments, or medical care your child receives on a regular basis that medical personnel may need to know about at the time of treatment for illness or injury.

CONSENT TO MEDICAL TREATMENT FOR A MINOR CHILD:

I understand that in the case of a serious medical emergency, unless the injury/illness appears to be immediately life-threatening, the staff and/or adult volunteers will make reasonable attempts to contact me as specified above *before* authorizing medical treatment. If I am not available to give consent, I hereby authorize the staff and/or adult volunteers of the Archdiocese of Indianapolis, New Albany Deanery Catholic Youth Ministries, or St. John Paul II Catholic Church to act on my behalf, to call 911 emergency services; transport by ambulance; hospitalize; secure proper treatment; authorize injections, anesthesia, x-ray, surgery or other treatment for my child as deemed necessary by qualified medical personnel. I also understand that the medical information provided will be shared only on a medical "need-to-know" basis among staff and/or adult volunteers and with treating medical personnel. **Notice is hereby given** to qualified medical personnel that this authorization is currently in effect, and such personnel are directed to act upon this authorization without delay. I agree to assume financial responsibility for all expenses incurred in any emergency requiring medical attention.

Parent/Guardian Signature: **Relationship:** **Date:**