PERMISSION SLIP

<First Last of Participant> <MorF> <01/01/2005> <Gr> (XXX) XXX-XXXX

Participant's Name (Please print) Gender Date of Birth Grade Home Phone

<123 Any Street> <City, State, Zip>

Address City/State/Zip

<First Last Name of Parent> (XXX) XXX-XXXX (XXX) XXX-XXXX

Parent/Guardian's Name Cell Phone Work Phone

Safety: As the participant, I agree to follow all procedures, safety precautions, and rules and regulations set forth by the Diocese and the Parish.

Signature of Participant Date

Parental Permission and Liability Release: As parent/legal guardian of the participant names above, I give my permission to participate fully in <e.g. NVJCYO basketball> (*Name of Program or Trip*) from <e.g., 10/1/15> *(Start Date/Time)* to <e.g. 2/1/16> *(End Date/Time)*. I agree to indemnify and hereby release the Most Reverend Paul S. Loverde Bishop of the Catholic Diocese of Arlington and his successors in office, as well as the Catholic Diocese of Arlington and all Diocesan clergy, employees, volunteers, and participating parishes and schools from any and all liability, claims, demands for personal injury, sickness and death, as well as property damage and expenses of any nature whatsoever which may be incurred by the undersigned of the participant resulting from said participant's involvement in the above mentioned event (including transportation to and from the event). Furthermore, I on behalf of the participant hereby assume all risk of personal injury, sickness, death, damage, and expenses resulting from said participant's involvement in the above described event.

Informed Consent to Medical Treatment: I request 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. I assume full responsibility for all costs of such treatment. Further, should it be necessary for the participant to return home due to medical, disciplinary, or other reasons, I do hereby assume responsibility for the participant's transportation home and any costs related thereto.

Photo, Press, Audio, and Electronic Media Release: I authorize the Catholic Diocese of Arlington, its parishes, its schools and/or the Arlington Catholic Herald to use and publish my child's photograph, video and/or audio recording along with their name identifying them for educational, news stories, illustration and/or marketing purposes.

Emergency Contact: Name <First Last of Emergency Cont> Relationship: <Relation of Em Contact to Youth>

Phone Number: (H) (XXX) XXX-XXXX Em Cont #Home (W) (XXX) XXX-XXXX Em Cont #Work (C) (XXX) XXX-XXXX Em Cont Cell

Health Information: Are there any medical conditions which may affect the participant's involvement in the above event? <List medical conditions, or if none, write NONE>

Are there any known allergies including any allergies to medicine? <List allergies or, if none, write NONE>

<List allergies>

Physician and Medical Insurance: Primary Healthcare Provider <First Last of Doctor> Phone (XXX) XXX-XXXX of Dr.

Insurance Company <Name of Insurance Company> Policy Number: <Policy Number of Insurance>

I understand and hereby agree to the terms and conditions of the participant's involvement in the above described event and I freely execute this Acknowledgement with full knowledge of its content.

Signature of Parent or Legal Guardian Date

Revised: 8/18/2016