

**ST LUKE CATHOLIC CHURCH  
2807 OAKDALE  
TEMPLE, TX 76502  
254-773-8874**

2008-2009 Academic Year Permission/Medical/Liability Release Form

Dear Parent or Guardian,

We are happy that your high school (9<sup>th</sup>, 10<sup>th</sup>, 11<sup>th</sup>, 12<sup>th</sup> grades) child/children will be participating in the current year's Keysis Youth Ministry Program. For our records and for any possible emergencies that might arise while at class, whether at church or in a home or on field trips, we ask that you please fill out and sign this form and this will act as Medical and Liability Release also. Notices will be sent home prior to field trips at least one week in advance with the student or by mail. It is the responsibility of the student to get the notice home. If the student is absent when the notes are sent home, verbal notification of the field trip, by phone or e-mail, will be attempted by the authorized person or Youth Ministry Coordinator. Please note that your signature is required in two (2) places. Please be sure all information is correct. If any changes occur during the year, it is your responsibility to contact the Keysis Youth Office.

**Student(s) Information**

1. Name: \_\_\_\_\_ Grade: \_\_\_\_\_  
2. Name: \_\_\_\_\_ Grade: \_\_\_\_\_  
3. Name: \_\_\_\_\_ Grade: \_\_\_\_\_  
Phone Number: \_\_\_\_\_ 2nd Phone Number \_\_\_\_\_

**Parent/Guardian Permission**

I hereby consent to participation by my son/daughter(s), in St Luke Keysis High School Youth Ministry program for the 2008-09 academic year. I understand that this program will take place on the parish grounds or away at homes or grounds chosen by the Youth Ministry Coordinator. My son/daughter(s) will be under the supervision of the authorized parish personnel.

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Signature

Date

### Medical and Emergency Information

My child is allergic to: Name or Number

\_\_\_\_\_

Please note specific medical problems: Name or Number

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

In case of emergency, notify (include two names with phone numbers):

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

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

Physician's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

I grant permission for non-prescriptive medication and routine non-surgical medical care to be given to my child if deemed advisable by the supervising parish personnel. In case of an emergency, I also grant permission to transport my child to the nearest hospital for emergency medical or surgical treatment. I will be contacted as soon as possible and will be advised prior to any further treatment by the hospital doctor.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Insurance Carrier/Policy

Number: \_\_\_\_\_

If participant has no insurance, cash payment in full for the necessary medical care is the responsibility of the parent or legal guardian.