

**St. Luke's /Holy Trinity CHS
Liability/Medical Release Form**

Student's Name: _____ Birth Date: _____

Address: _____ Grade: _____

City: _____ State: _____ Zip: _____

Phone: (_____) _____ Email: _____

Parent/Guardian, please fill out the following (if participant is under age 18):

I, _____ (parent's name, if participant is under age 18), give permission to my above named son/daughter to attend **Discipleship Week, June 22-25, 2009**. If needed for health reasons, I give permission for my child to be evaluated, diagnosed, treated, and/or given medication in accordance with standard medical practice by licensed medical personnel. I relieve the Diocese of Austin, St. Luke Catholic Church, Holy Trinity CHS, its staff members and volunteers of all responsibility and consequence that may arise as a result of this treatment. I will not hold the Diocese of Austin, St. Luke's Catholic Church, Holy Trinity CHS, its personnel, or volunteers liable in the event of injury. Further, I agree to accept any and all financial responsibility as a result of scheduling medical treatment.

My child agrees to abide by all the rules and regulations stated by St. Luke's/ Holy Trinity and the Youth Ministry Staff. I understand that St. Luke's/Holy Trinity will not be liable if my child fails to cooperate with regulations, and that any infraction of the rules may result in immediate dismissal from this activity at my expense.

Parent's/Guardian's Signature _____

Participant's Signature _____

Family Physician: _____ Phone: (_____) _____

Allergies: _____ Current Medications: _____

Medical History: _____

In Case of Emergency, please contact:

Name _____ Name _____

Phone _____ Phone _____

One form must be completed for each person attending!