FORM A

PARISH _____

Archdiocese of Newark
Office for Youth Ministry – Summer Service Week

PARENTAL/GUARDIAN CONSENT FORM AND LIABILITY WAIVER

PARTICIPANT'S NAME: _____ BIRTH DATE:_____ Cell Phone # _____

PARENT/GUARDIAN'S NAME:_____

HOME ADDRESS:_____ E-mail Address_ _____

HOME PHONE:_____EMERGENCY PHONE_____

I, (name of parent or guardian)_____, grant permission for my child (name of child)

_____ to participate in the Archdiocese of Newark Youth Ministry Summer Service Week to be held at the St. JPII Youth Retreat Center and in parishes throughout the Archdiocese of Newark, NJ July 21-26, 2024 (the "Program") .

For value received, I agree on behalf of myself, my child's other parent if known or living (name of parent) _____ _____, my child named herein, or our heirs, successors, and assigns, if any claim for my child's personal injury or wrongful death is commenced against the Archdiocese of Newark, Office of Youth and Young Adult Ministry ("OYM"), or the parishes involved in the aforementioned activity(ies), to defend, indemnify, and hold harmless OYM, its officers, directors, and agents, and all parishes within the Archdiocese, and the officers, agents, representatives, volunteers, and employees of either the Archdiocese or any parish thereof, and chaperones or representatives associated with the "Program" with respect to any and all actions, claims, or demands that may be made or brought against OYM, its officers, directors and agents, and the Archdiocese of Newark and all parishes within the Archdiocese, and the officers, agents, representatives, volunteers and employees of either the Archdiocese or any parish thereof, and chaperones or representatives associated with the "Program", arising from or in connection therewith, and I agree to compensate OYM, its officers, directors and agents, and the Archdiocese of Newark and all parishes within the Archdiocese, and the officers, agents, representatives, volunteers and employees of either the Archdiocese or any parish thereof, and chaperones or representatives associated with the "Program" for reasonable attorney's fees and expenses arising in connection therewith.

MEDICAL MATTERS: I hereby warrant that to the best of my knowledge, my child is in good health, and I assume all responsibility for the health of my child. Of the following statements pertaining to medical matters, ***sign only those in accordance with your wishes.***

Emergency Medical Treatment: In the event of an emergency, I hereby give permission to OYM, its officers, directors and agents, and the Archdiocese of Newark and all parishes within the archdiocese, and the officers, agents, representatives, volunteers and employees of either the archdiocese or any parish thereof, and chaperones or representatives associated with the "Program" to transport my child to a hospital for emergency medical or surgical treatment. I wish to be advised prior to any further treatment by the hospital or doctor. In the event of an emergency, if you are unable to reach me at the above numbers, contact:

NAME and RELATIONSHIP: _____

Telephone: _(_____)_____

FAMILY DOCTOR: _____

Telephone:__(_____)_____

FAMILY HEALTH PLAN CARRIER:_____

Policy Number:_____

(1) Signature: _____Date:_____

PLEASE TURN OVER AND COMPLETE BACK OF THIS FORM

Other Medical Treatment: In the event it comes to the attention of OYM, its officers, directors and agents, and the Archdiocese of Newark and all parishes within the archdiocese, and the officers, agents, representatives, volunteers and employees of either the archdiocese or any parish thereof, and chaperones or representatives associated with the "Program", that my child becomes ill with symptoms such as headache, vomiting, sore throat, fever, diarrhea, I want to be called REGARDLESS of the Time, etc.

Signature:_____ **Date:** _____

Medications: My child is taking medication at present. My child will bring all such medications necessary, and such medications will be well-labeled. Names of medications and concise directions for seeing that the child takes such medications, including dosage and frequency of dosage are as follows:

(3) Signature: _____ **Date:** _____

No medication of any type whether prescription or non-prescription may be administered to my child unless the situation is life-threatening and emergency treatment is required.

(4) Signature_____ **Date:** _____

I hereby grant permission for non-prescription medication (such as aspirin, throat lozenges, cough syrup) to be given to my child, if deemed advisable.

(5) Signature: _____ **Date:** _____

Specific Medical Information: OYM, will take reasonable care to see that the following information will be held in confidence.

Allergic reactions (medications, foods, plants, insects, etc.) _____

Immunizations: Date of last tetanus/diphtheria immunization: _____

Medications child currently takes _____

Does child have a medically prescribed diet? _____

Any physical limitations? _____

Is child subject to chronic homesickness, emotional reactions to new situations, sleepwalking, bedwetting, fainting? _____

Has child recently been exposed to contagious disease or condition, such as mumps, measles, chicken pox, etc.? _____

If so, date and disease or condition:_____

You should also be aware of these special medical conditions of my child _____

_____

I fully understand the consequences of the foregoing statements and sign this **PARENTAL/GUARDIAN CONSENT FORM AND LIABILITY WAIVER** knowingly, freely, and willingly. **(Your signature must appear below or your child will not be permitted to attend the "Program")**

(6) Signature: _____ **Date:** _____

Parent or guardian must sign lines numbered 1 and 6.