PHOTO RELEASE

I understand that through their participation in this program, my child(ren) listed on this registration may be photographed for use in promotion of diocesan programs.
As parent/legal guardian, I ___ DO GIVE ___ DO NOT GIVE permission for my child(ren) photographed during this program.

Parent Signature ____ Date __________________________

MEDICAL TREATMENT RELEASE

As a parent/legal guardian, I do hereby authorize first aid/medical treatment of my child in the event of an emergency which may endanger his/her life, cause disfigurement, physical impairment, or undue discomfort if delayed. It is understood that efforts will be made to reach me as soon as reasonably possible. In the event that the aforementioned required my authorization for treatment and I cannot be reached in an emergency, I hereby give my permission to the physician selected by the activity leader to hospitalize, secure medical treatment, and/or order an injection, anesthesia or surgery for the aforementioned as deemed necessary.

I understand that all reasonable safety precautions will be taken at all times by the parish and its agents during faith formation programs. I understand the possibility of unforeseen hazards and know the inherent possibility of risk. I agree not to hold St Robert of Newminster Parish, its leaders, employees, drivers, volunteers, or the Roman Catholic Diocese of Grand Rapids liable for damages, losses, diseases, or injuries incurred by the aforementioned.

Name of child(ren)		**Relationship to you**
Reason for which release is intended:	**Faith Formation Sessions & Activities**	
	Youth Ministry Events & Activities	
	Children's Choir	
Address of child		**Home Phone**
Parent Name		**Mobile Phone**
Family Physician		**Physician Phone**
Physician Address/City/State/Zip		
List allergies, current medications, glasses/contacts, physical/mental/learning disabilities, dietary needs, or other pertinent information:		
Health Insurance Information:		
Company		**Policy #**
Group #		**Contact #**

This release form is completed and signed of my own free will with the sole purpose of authorizing medical treatment under emergency circumstances in my absence.

I certify that I am ***(check one)*** _____ **Custodial Parent** _____ **Legal Guardian**
of the minor child(ren) named above, and I agree to the above terms for myself and for my minor child(ren).

Parent Signature	**Date**

Check if online signature	