

*Archdiocese of Galveston-Houston / St. John Vianney Catholic Church*  
***Laser Quest: August 25, 2010***

**PARENTAL/GUARDIAN CONSENT, LIABILITY WAIVER AND MEDICAL  
CONSENT**

Participant's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Home Address \_\_\_\_\_  
City \_\_\_\_\_ Zip Code \_\_\_\_\_  
Parent/Guardian \_\_\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_\_  
Alternate Phone Number: (\_\_\_\_) \_\_\_\_\_  Cell Phone or  Pager  
Parish \_\_\_\_\_ Grade \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_  
Teen's E-mail \_\_\_\_\_ T-Shirt Size \_\_\_\_\_

**CONSENT & LIABILITY WAIVER**

**Important! To be filled out by the Parent/Guardian for youth under 18 years of age.  
If participant is 18 years of age or older, consent must be signed by the individual)**

I (name of parent/guardian) \_\_\_\_\_, grant permission for my  
child, (participant's name) \_\_\_\_\_, to participate in Laser Tag at Laser  
Quest on August 25, 2010 from 6:30 p.m. to 8:30 p.m.

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, to hold harmless and defend the Archdiocese of Galveston-Houston, St. John Vianney  
Catholic Church (its pastor, youth minister, other agents, etc.), the sponsoring parish (its pastor, youth minister, other agents, etc.) or  
any representatives associated with the scheduled activity unless the parties involved were careless or negligent.

\_\_\_\_\_  
**Signature (Parent/Guardian)**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Signature (Participant 18 years of age or older must sign own consent)**

\_\_\_\_\_  
**Date**

**PHOTOGRAPHY CONSENT**

As parent/guardian, I understand that promotional pictures (individual and group) will be taken during this event. I give permission  
for my son's/daughter's picture to be used for promotional materials (newsletter, web page, calendars, power point, etc.) in  
highlighting the event.

\_\_\_\_\_  
**Signature (Parent/Guardian)**

\_\_\_\_\_  
**Date**

## MEDICAL CONSENT

### Medical Matters

I hereby warrant 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 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 even of an emergency and you are unable to reach me, contact:

Name & Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Family Doctor \_\_\_\_\_ Phone \_\_\_\_\_

### Medications

My child will bring all such medications, well labeled, that are necessary. Names of medications and concise directions for seeing that the child takes such medications, including dosage and frequency are as follows

My child is taking the following medication at the present time.

Medication(s): \_\_\_\_\_ Dosage: \_\_\_\_\_

**Administer:** \_\_\_\_\_

\_\_\_\_\_ I hereby **Do Not Grant Permission** for medication of any type, whether prescription or nonprescription may be administered by my child unless the situation is life threatening and emergency treatment is required. (Please initial)

\_\_\_\_\_ I hereby **Grant Permission** for nonprescription medication (such as Tylenol, throat lozenges, cough syrup) to be given to my child, if deemed advisable. I understand that Aspirin will not be given to my son/daughter. (Please initial)

### Medical Conditions Information

(Archdiocesan personnel will take reasonable care to see that the following information will be held in confidence.)

My son/daughter has:

Has had an episode the following or has been diagnosed:  Seizures     Asthma     Diabetic

Allergic reactions to the following (foods, dyes, latex etc.) \_\_\_\_\_

Has had a medical surgery within the last six months?  Yes     No    Still under doctor's care?  Yes     No

Has a medically prescribed diet? \_\_\_\_\_

The following physical limitations? \_\_\_\_\_

Immunizations current and up to date:  Yes  No    Date of last tetanus/diphtheria immunization \_\_\_\_\_

You should also be aware of these special medical conditions of my child: \_\_\_\_\_

### Insurance Information

(Please attach a copy of the Insurance Card, front and back, with this form)

No, I do not carry medical insurance at this time.

Insurance Carrier: \_\_\_\_\_

Name of Insured: \_\_\_\_\_

Insurance Policy Number: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Day Phone: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Day Phone: \_\_\_\_\_

In the event it comes to the attention of the chaperones associated with the activity that my child becomes ill with repeated symptoms such as headache, vomiting, sore throat, fever, diarrhea, I want to be called immediately. If this will be a long distance call, I want to be called collect (with phone charges reversed to myself).

*I fully understand the foregoing statements and sign this Parental/Guardian Medical Consent Waiver knowingly, freely, and willingly.*

\_\_\_\_\_  
**Signature (Parent/Guardian) Parent/Guardian must sign for anyone under 18 years of age.**      **Date** \_\_\_\_\_

\_\_\_\_\_  
**Signature (Participant 18 years of age or older must sign own consent)**      **Date** \_\_\_\_\_