

**Please send this form back to Resurrection Parish if you will be participating in any or all of these events**

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

Grade \_\_\_\_\_ Date of Birth \_\_\_\_\_

Home Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Parent Cell Phone \_\_\_\_\_

E-mail: \_\_\_\_\_

**Drop off or mail to:**  
Resurrection Parish  
Attn: Rachel  
333 Hilltop Dr.  
Green Bay, WI 54301

**Check which event/s you plan on attending**

- St. Vincent de Paul** February 15
- West Side Boys and Girls Club** March 21
- McCormick Home** April 4
- Scavenger Hunt Food Drive** May 2



**FILL OUT PERMISSION AND MEDICAL RELEASE ON THE BACK**

**PARENTS: We need your help for these events with the following:**

- Donating food
- Helping to chaperone

I'd be happy to help! CIRCLE CHAPERONE OR FOOD AT THE TOP

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

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

Which event/s can you help with \_\_\_\_\_

Are you VIRTUS trained and background check? YES NO

I grant permission for my child to participate in the events offered by Resurrection Parish (held at Resurrection or offsite) These activities will take place under the guidance and direction of parish/school employees and/or volunteers.

As parent and/or legal guardian, I remain legally responsible for any personal actions taken by the above named minor. I agree on behalf of myself, my child named herein, or our heirs, successors, and assigns, to hold harmless and defend Resurrection Catholic Parish, its officers, directors and agents, and the Catholic Diocese of Green Bay, coaches, chaperones, DRIVERS or representatives associated with the activity from all claims, liabilities, damages, costs, losses and expenses, including reasonable attorney fees arising in connection therewith.

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

## MEDICAL RELEASE

**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 that are applicable.)

**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 event of an emergency, if you are unable to reach me at the above numbers, contact:

Name & relationship: \_\_\_\_\_  
Phone: \_\_\_\_\_ Family doctor: \_\_\_\_\_ Phone: \_\_\_\_\_  
Family Health Plan Carrier: \_\_\_\_\_ Policy #: \_\_\_\_\_  
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:

Please initial your choice(s):

- \_\_\_\_\_ I hereby grant permission to give my child the prescribed medication above.
- \_\_\_\_\_ I hereby grant permission for non-prescription medication (such as aspirin, throat lozenges, cough syrup) to be given to my child, if deemed appropriate.
- \_\_\_\_\_ ONLY after immediate contact with myself or a named representative on previous page under medical matter, I hereby grant permission for non-prescription medication to be given to my child.
- \_\_\_\_\_ No medication of any type, whether prescription or non-prescription, may be administered to my child.

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

**Specific Medical Information:** The parish/school will take reasonable care to see that the following information will be held in confidence. List any allergic reactions (medications, foods, plants, insects, etc.):

Is your child's tetanus shot up to date? : YES or NO

Any physical limitations? \_\_\_\_\_

Has child recently been exposed to contagious disease or conditions, such as mumps, measles, chickenpox, etc.? If so, date and disease or condition:

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

