

MIDDLE SCHOOL YOUTH MINISTRY (6-8th Grade)

**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 _____

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 Service Project February 15

Tie Dye Night March 7
WHAT SIZE T-SHIRT DO YOU WEAR? _____

Bus trip to the Shrine of Our Lady of Good Help April 25

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

PERMISSION

I grant permission for my child to participate in the events offered by Resurrection Parish (held at Resurrection Church, St. Vincent De Paul, and The Shine of Our Lady of Good Help). 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, Bus 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 provided numbers, contact:

Name & relationship: _____
Phone: _____ Family doctor: _____ Phone: _____
Family Health Plan Carrier: _____ Policy #: _____
Signature: _____ Date: _____

Medications: My child is taking medication at present. List medications below:

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: _____