

Family Name _____ Phone _____ E-mail _____

(Please Print)

Release and Discharge of Liability

Medical Release and Permission Grades K - 12

I/We, the parent(s)/guardian(s) of: 1) _____, 2) _____

Child & Grade

Child & Grade

3) _____ 4) _____ 5) _____

Child & Grade

Child & Grade

Child & Grade

allow my son(s)/daughter(s), (list each child) _____

_____ to participate in Sacred Heart Religious Education/CYF (elementary, middle school & high school) programs and in all related projects and activities. In consideration of making these arrangements for the religion program, I/we hereby release and save harmless Sacred Heart Catholic Church, its employees, and volunteers from any and all liability for any injury resulting from involvement in the Religious Education or any related project or activity. In consideration for permitting my child(ren) to participate in this activity, I/we _____ agree on behalf of my/our child(ren) _____

_____ and myself, our heirs, assigns, executors and personal representatives to release and hold harmless Sacred Heart Catholic Church, the Roman Catholic Archdiocese of Kansas City in Kansas, their officers, directors, agents, employees, chaperones and official representatives from any and all liabilities, claims, loss or damages arising from or in connection with my/our child's(ren's) participation in Sacred Heart Religious Education classes and activities. To the best of my(our) knowledge, my(our) child(ren) is/are in good health and physically able to participate in this program. I/We also allow photos taken at parish events, which may include my(our) child(ren) to be published in parish media, such as the bulletin, digital announcements and the website.

In order to meet all legal requirements, I/we also give my permission for (list each child)

_____ to be treated by a qualified medical doctor in the case of medical emergency.

My/Our child(ren) may receive over the counter medications. Yes No (Circle one.)

Signed: _____ Date: _____

Parent(s)/Guardian(s)

Parent(s)/Guardian(s) _____ Phone # _____

Work # _____ Cell # _____

Medical Insurance Company: _____

Policy number: _____

Subscriber's name: _____

Allergies or other pertinent medical information: (ADD, epilepsy, asthma...) _____

Medications taken on a regular basis: _____

Emergency contact phone numbers:

1) Name _____ phone # _____ Relationship _____

2) Name _____ phone # _____ Relationship _____