Form A rev. 8/2010

School/Parish St. Francis of Assisi-OKC School/Parish Year: 2016 through 2017

REGISTRATION CONSENT AND WAIVER FORM for RE/YOUTH ACTIVITIES

This Form must be completed and executed for participation in the RE/Youth Activities as a part of registration.

(Please print)
Participant's Name: _____ Birth Date: _____ Age: _____ Girl/Boy: _____

Address: _____ City/State: _____ Zip: _____

Home Telephone: (_____) _____

Participant resides with (check all that applies): Mother _____ Father _____ Guardian(s) _____

Custodial Parent/Legal Guardian's Name: _____

Home Address: _____ City/State: _____ Zip: _____

Home Telephone: (_____) _____ Business (_____) _____ Cell (_____) _____

Emergency Contact: _____ Relationship: _____
Home Telephone: (_____) _____ Cell: (_____) _____

Second Contact: _____ Relationship: _____
Home Telephone: (_____) _____ Cell: (_____) _____

PARTICIPATION PERMISSION: I, the undersigned, am custodial parent/legal guardian of Participant and request that he/she be to allowed participate in the RE/Youth programs, events and activities to be held at St Francis of Assisi-okc parish during the 2016/2017 school/parish year (the "RE/Youth Activities"). I understand that the RE/Youth Activities consist of weekly sessions and related activities which may be held from time-to-time.

LOST OR STOLEN ITEMS: I hereby understand and agree that neither the Archdiocese of Oklahoma City or St Francis of Assisi - okc (Parish/School Name) nor any of their respective employees, directors, officers, agents, representatives and/or volunteers shall be held liable for any of my or my child's personal property lost or stolen during participation in the RE/Youth Activities.

MEDICAL INFORMATION: Is Participant taking any medications **OR** have any medical conditions (e.g., diabetes, epilepsy, heart conditions, etc.) _____ yes _____ no **If yes**, explain (attach additional sheets as necessary):

_____

Does your child have any allergies? (e.g., insects, hay fever, strawberries, peanuts, etc.) _____ yes _____ no **If yes,** explain (attach additional sheets as necessary):

_____

Does your child have any allergies or adverse reactions to medications? (e.g., penicillin, ibuprofen, acetaminophen, etc.) ___ yes ___ no **If yes,** explain (attach additional sheets as needed):

_____

Does your child have any disabilities or physical or developmental limitations? ___ yes ___ no **If yes,** explain (attach additional sheets as necessary):

_____

Date of last tetanus immunization: _____
Participant's Primary Physician: _____ Telephone: (_____) _____
Health Plan Carrier: _____
Group# : _____ Policy#: _____
Name of primary insured: _____

_____ **(Parent Initial)**