

Division of Youth Registration Form

Participant's Name _____ Goes by _____

Male ___ Female ___ DOB _____ Age _____ Grade _____

Home Address _____

City _____ Zip _____ Home Ph.# _____

Email _____ Parent/Guardian Work Ph _____ Parent/Guardian Cell
Ph _____

If unavailable in emergency, notify _____ Ph# _____

Allergies to medications and reaction _____

Medications sent with participant _____

Note: Prescribed medications must be in original pharmacy container with the correct name, date, instructions and physicians name on label. Over- the-counter medications must be in original container and have dosage information clearly printer on container. The event nurse will keep and distribute all medications during the event. Please notify the event coordinator or nurse if this participant has been exposed to any communicable disease within the 3 weeks prior to this event. Participants will NOT be allowed to attend if they arrive at the event ill.

Are there any over the counter medications that the participant **should not** receive if any minor symptoms develop? (i.e. Tylenol, Advil, Kaopectate, etc.) _____

Insurance Co. _____

Policy # _____ Group# _____ Insurance Co. _____

Ph# _____

My Child, _____, has my permission to attend and to participate in _____ **(name of event)** sponsored by the Episcopal Diocese of Texas and Trinity Episcopal Church. I represent that my child is healthy and capable of participating in said event without causing risk of danger, illness or accident to him/herself, or to others. I agree to hold harmless the leaders of my church, the leaders of other churches involved, the event coordinators, the Bishop of Texas and the Diocese of Texas in the event of any accident or injury.

In the event that my child requires medical attention while attending the event, I understand that an adult sponsor of the event will make every reasonable attempt to contact me. In the event that I cannot be contacted, I consent to any medical attention deemed appropriate. In the event that treatment is called for, which the medical provider refuses to administer without consent, I hereby authorize an adult sponsor to give such consent for me if I cannot be contacted immediately or, because of an emergency, there is no time or opportunity to make contact. In the event that it is necessary for that person to give consent, I agree to hold such person free and harmless of any liability for damages arising from giving such consent. I declare that my child is covered by medical insurance and/or that I am responsible for any and all expenses incurred by my child whether covered under insurance or not.

As parent/guardian, I understand that promotional pictures and videos (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, video etc.) in highlighting the event.

Custodial Parent or Legal Guardian Signature: _____ Date _____

Relationship to Participant: _____

Phone number where I can be reached during the event: _____