FAN the FIRE® YOUTH RALLY at St. Joseph Church, York, PA – **NOVEMBER 11, 2017**

LIABILITY/MEDICAL RELEASE FORM – *YOUTH PARTICIPANT*

ONE FORM MUST BE COMPLETED FOR EACH YOUTH ATTENDING!

Participant's Name_____ Birth Date_____

Address_____ Year of Graduation_____

City_____ State_____ Zip_____ Phone#_____ E-mail_____

Group Name_____ City/State_____

Group Leader's Name_____

PARENT/GUARDIAN

I,_____(name), give permission to my above-named son/daughter to attend the Fan the Fire® Youth Rally to be held on November 11, 2017 at St. Joseph Church in York, PA. If needed for health reasons, I give permission for my child to be evaluated, diagnosed, treated and/or given medication in accordance with standard medical practice by licensed medical personnel. I relieve St. Joseph Roman Catholic Church of all responsibility and consequences that may arise as a result of this treatment. I will not hold St. Joseph Roman Catholic Church in York PA liable in the event of injury. Further, I agree to accept any and all financial responsibility as a result of scheduling medical treatment.

My child agrees to abide by all rules and regulations stated by St. Joseph Church and the Fan the Fire® youth rally staff. I understand that St. Joseph Roman Catholic Church will not be held liable if my child fails to cooperate with regulations, and that any infraction of the rules may result in immediate dismissal from the youth rally at my expense.

I give permission to St. Joseph Church to photograph, videotape and/or film my child and to use his or her image in photographs, video, and/or film for the purpose of promoting the mission, activities and programs of the Fan the Fire® Youth Rally. I understand that specific names of any individual participant will not be mentioned with any photos used for these stated purposes. I understand that I and my child are not entitled to any compensation or rights in these materials, and I release St. Joseph Church from any liability for the use of my child's image for the above stated purposes.

SIGNATURE OF PARENT/LEGAL GUARDIAN_____ Date_____

Family Physician_____ Phone#_____

Allergies (be specific)_____

Current Medications_____

Medical History (be specific)_____

Medical Insurance Provider_____ Insurance #_____

In case of emergency, please contact:

Name_____ Name_____

Address_____ Address_____

_____ _____

Phone#: Home_____ Phone#: Home_____

Work_____ Work_____