



DIOCESE OF FALL RIVER

CATHOLIC EDUCATION CENTER

DEPARTMENT OF FAITH FORMATION

423 Highland Ave

Fall River, Massachusetts 02720

PARENTAL CONSENT/RELEASE AGREEMENT

I _____, the parent/guardian of _____,
(Print Name of Parent/Guardian) *(Name of Child)*

in consideration of my request to allow this child the opportunity to participate in _____
(Event Name)

to _____ on _____
(Location of Event) *(Date)*

agree to assume all responsibility associated with this event. I grant to the Parish and the Diocese of Fall River, its agents, employees, and representatives my permission to seek emergency medical attention for this child if, in their judgment, such attention is warranted and I am not immediately available to grant such permission. I agree to be in all ways responsible for any and all expenses associated with any and all medical care furnished to this child.

The Diocese of Fall River has sufficiently explained the nature, extent, and requirements of this event and I am aware of and accept the associated risks of participation in this event. I agree to release and hold the Parish and the Diocese of Fall River and their agents, employees, and representatives, forever harmless and indemnified against and from any and all claims or right of action for damages which my child has or hereafter may acquire either before or after the child has reached majority, including but not limited to all bodily injuries and property damages, and including any legal fees in defending such a claim, resulting from, arising out of, or during, or in any way connected with this event. I also agree to release and hold the Parish and the Diocese of Fall River and their agents, employees, and representatives, forever harmless and indemnified against and from any and all claims or right of action for damages which my child has or hereafter may acquire either before or after the child has reached the majority, including but not limited to all bodily injuries and property damages, and including any legal fees in defending such claim, resulting from, arising out of, or during, or in any way connected with this event.

(Signature of Parent/Guardian) *(Date)*

Emergency Telephone Number(s) where Parent/Guardian can be reached during the event:

(1) (____) _____; (2) (____) _____; (3) (____) _____

Does your child need to administer any **prescription/ over the counter** medication during this event? **NO** **YES**
If yes, please list the medication(s) and their dosages below. Please use the back of this form for additional information.

Medication _____ Dosage _____

Medication _____ Dosage _____

Does your child have any allergies to food and/or medications? **NO** **YES** If yes, please list & explain:

Participant's Primary Care Physician's Name: _____

Physician's Phone: _____

Child's Medical Insurance Company: _____

Policy Number: _____