

**Archdiocese of Baltimore**  
**PERMISSION FORM & RELEASE**

St Paul's Church  
 3755 St Paul St  
 Ellicott City, MD 21043  
 410-465-1670

<i>Youth Name:</i>	<i>Home Phone:</i>
<i>Parent(s) Name:</i>	<i>Other Number Where Parent Can Be Reached:</i>
<i>Address:</i>	<i>E-Mail: (Youth's or Family's)</i>
<i>City/State/Zip:</i>	<i>Youth's Social Security Number:</i>
<i>Youth's Date of Birth:</i>	<i>Youth's Gender: (Circle one)</i> <div style="text-align: center;"><i>male                      female</i></div>

In consideration of the wholesome recreational and learning experience in which my son/daughter will participate, I as parent or guardian of my son/daughter, do hereby agree to allow my son/daughter to accompany the youth ministry group of St Paul's Parish to:  
 (event)                      (location)                      (date/time)

I/we acknowledge receipt of the attached information sheet describing the planned activities.

In consideration of the opportunity for my son/daughter to participate in the Program, I agree to **RELEASE AND HOLD HARMLESS AND INDEMNIFY** St Paul's Church and parish, Howard County Youth Ministry, the Division of Youth & Young Adult Ministry, the Roman Catholic Bishop of Baltimore and his successors, a Corporate Sole, and all their agents, servants, and employees from any liability, claims, demands and causes of action arising out of or relating to any loss, damage or injury sustained in connection with or arising out of my son/daughter's participation in the Program.

I hereby grant permission to any staff person to obtain medical care from a licensed physician, hospital, or medical clinic for my son/daughter in the event I cannot be reached.

*(Check one of the following:)*

I am covered by hospitalization and medical insurance under policy

# \_\_\_\_\_

issued by \_\_\_\_\_.

I do not have medical coverage and assume responsibility for the cost of hospitalization and medical care for my son/daughter.

I hereby grant permission to any staff person to provide the following over-the-counter drugs to my son/daughter if requested by my son/daughter. (Check all that apply:)

Tylenol    Benadryl    Advil    Sudafed    Midol    Kaopectate    Neosporin    Pepto Bismol

**(over/go to page 2)**

ADD any other medical information concerning medications, allergies, illness, etc \_\_\_\_\_

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ADD any dietary restrictions: \_\_\_\_\_

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Parents/guardians of participants are advised that photographs or videotape of participants may be used in publications, websites or other materials produced from time to time by the Division of Youth and young Adult Ministry or the Archdiocese of Baltimore. (participants would not be identified, however, without specific written consent.) Parents/guardians who do not wish their child(ren) to be photographed or filmed should so notify the Division in writing. Please note that the Division has no control over the use of photographs or film taken by media that may be covering the event in which your child(ren) participate(s)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Signature(s)

I understand the rules

\_\_\_\_\_  
Child's Signature