

Just5Days

Youth Consent and Health Form

(Your signature indicates your consent and acceptance of the provisions included in this document.)

Just5Days Program Site Kansas City

Program Starting Date (month/day/year) June 24, 2019

Participant Name _____ Date of Birth _____

Parish/School St. John the Evangelist City & State Viola, Kansas

Age _____ Gender _____ Home Phone (____) _____

Work or Cell Phone: Father (____) _____ Mother (____) _____

Parent email address _____

Mailing Address _____

City/State/ZIP _____

PARTICIPATION CONSENT: I, (Name of Parent or Guardian) _____
grant permission for my son/ daughter to participate in the *Just5Days* program.

LIABILITY WAIVER: I will not hold the Center for Ministry Development, any CMD staff, the program facility, or the service agency responsible in the event of any injury or accident to my son or daughter while participating in the *Just5Days* program and/or traveling to and from program activities.

USE OF PHOTOS: I give the Center for Ministry Development permission to use photos or videos of my child taken during program activities for future program promotion purposes.

STATEMENT OF HEALTH: I hereby warrant that, to the best of my knowledge, my child is in good health and able to participate in all program activities. (Please submit a statement indicating limitations and/or conditions of which we should be aware.)

INSURANCE INFORMATION

Family Health Insurance Co.: _____ Policy No. _____

MOST RECENT PHYSICAL EXAMINATION (Provide information on your child's most recent examination)

Date of Examination: _____

Physician or Clinic: _____ Phone _____

Physician/Clinic Address _____

IMMUNIZATIONS: (Please provide date of latest tetanus immunization) _____

MEDICATIONS: Any medications brought to the program should be clearly labeled and in their original container. Please list any prescription or approved non-prescription drugs your child is presently taking. Include product name and physician's instructions on dosage and frequency.

I understand that all prescription medication will remain in the possession of the adult team leader and be dispensed as prescribed. I grant permission for non-prescription medication (such as ibuprofen, acetaminophen, throat lozenges, cough syrup) to be given to my child, if deemed advisable.

If there are any non-prescription drugs you do not want administered to your child, please list them below:

ALLERGIES (Please attach a statement noting all known allergies, including how the child has been treated and with what medication. If medications are needed occasionally or regularly, please send them with your child in case of need.)

OPERATIONS OR SERIOUS INJURIES (Within the past 18 months)

Operation/Injury _____ Date _____

COMMUNICABLE DISEASES: Please notify CMD if your child has been exposed to any communicable disease (mumps, measles, chicken pox, etc.) within three weeks prior to attending the *Just5Days* program.

MEDICAL EMERGENCY: In case of medical emergency, I understand that every effort will be made to contact the parents or guardians of participants. In the event that I cannot be reached, I hereby give permission to the physician selected by the *Just5Days* program director or parish adult leader to hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery for my child, as named herein.

SIGNATURE OF PARENT OR GUARDIAN: I certify that the above information is correct and give permission for my child to be transported in privately owned vehicles and/or via public transportation for approved *Just5Days* program activities; and for the release of medical records to an attending physician in case of illness. I fully understand the consequences of the foregoing statements and sign this form knowingly, freely, and willingly. (Your signature must appear below, or your child will not be permitted to participate in the *Just5Days* program.)

Signature _____ Date _____

RETURN TO: The leader of your parish or school *Just5Days* Team.