YOUTH FORM E
(Attach to Form 13 at NCYC)

National Catholic Youth Conference 2019

Catholic Diocese of Youngstown

YOUTH Individual Registration/Medical Permission Form

Please PRINT or TYPE all information, except signatures and complete both sides of this form:

Diocese Youngstown Region 6 Parish/School Group _____

Youth Legal First Name _____ Middle Initial _____

Nickname/Name for Badge _____ Last Name _____

Address _____ Date of Birth (mm/dd/yy) ____/____/____

City, State, Zip _____ Home Phone (_____)_____

Email Address _____ Cell Phone (_____)_____

Mother/Guardian _____ Cell Phone (_____)_____

- If different address: _____

Father/Guardian _____ Cell Phone (_____)_____

- If different address: _____

Circle ALL that apply: Sign Language Interpretation Needed Enhanced Listening Device Needed
Large Print Program Needed Braille Program Needed Low Gluten Host Needed
Scooter/Wheelchair Rental Information Needed Assistance Needed Getting Between Stadium/Convention Center

Please note: All areas utilized are not ADA accessible. Contact the OY&YAM if special arrangements need to be made.

Ethnicity: Asian/Pacific Islander Black Hispanic Native American White
Multi-Ethnic Not Known Other **Gender:** Male Female

Grade in 2019-2020: 9 10 11 12 **Shirt size**: S M L XL XXL XXXL

I am involved in: ___Boy Scouts ___Girl Scouts ___Venturing ___Campfire ___HS Campus Ministry

Youth Agreement I understand that my participation in this program requires compliance with specific rules and regulations by the NFCYM, Catholic Diocese of Youngstown and my parish/school group. I will follow these rules and shall abide by the Code of Conduct.

Youth Signature _____ **Date** _____

Parental Agreement

I, the parent/guardian of _____ who is less than nineteen years of age, grant permission for my daughter/son to participate in the National Catholic Youth Conference with _____ parish/school. By allowing my child to participate in the said program, I hereby assume all risk of accident or harm arising or growing out of, directly or indirectly, any incident of any kind occurring during the course of such program to my child and do hereby release and discharge the Bishop of the Diocese of Youngstown, the Office of Youth and Young Adult Ministry, and _____ parish/school, and the agents, associates, and employees of the Bishop and parish/school who have organized or participated in the supervision of such program from all claims, demands, suits, causes or actions, rights, costs, expenses, and any compensations whatsoever which may occur to my family and its members during or resulting from participating in the program mentioned.

Signature _____ **Date** _____

I am aware of the particulars of the said program including the times, costs, and adults chaperoning and/or transporting my child for the program and have clarified any concerns I may have with the coordinating adult in charge. I agree that my son/daughter shall abide by the Code of Conduct and all regulations of the program including regulations regarding alcoholic beverages, drugs, and weapons. I agree that if my son/daughter fails to abide by the regulations set forth, he/she may be dismissed from the program and I will need to arrange for his/her immediate transportation home at my expense.

Signature _____ **Date** _____

I understand that any photographs or video taken at this event may be used in diocesan publications.

Signature _____ **Date** _____

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Medical Information ***(Please check and sign ONLY those in accordance with your wishes.)***

☐ In the event of an emergency, I hereby grant permission to transport my son/daughter and obtain emergency medical or surgical treatment from a licensed physician, hospital, or medical clinic. I hereby authorize medical personnel to release necessary information about his/her care to Cindee Case of the Diocesan Office of Youth & Young Adult Ministry, as well as my parish group leaders(s) named here_____. I wish to be advised prior to further treatment by the hospital or doctor. In the event I cannot be reached, please contact:

Name _____ Phone (_____)_____

Relationship to youth _____

Family physician _____ Phone (_____)_____

(Please check one of the following)

☐ My son/daughter is covered by hospitalization and medical insurance under policy # _____ issued by _____.

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

Signature _____ **Date** _____

-- OR--

☐ I hereby warrant that to the best of my knowledge, my son/daughter is in good health. **I do not want any medical treatment to be given to my son/daughter under any circumstances.** I hereby assume all responsibility for the health and well-being of my son/daughter and release from responsibility the Bishop of the Diocese of Youngstown, and _____ parish/school, and the agents, associates, and employees of the Bishop and parish who have organized or participated in the supervision of such program.

Signature _____ **Date** _____

☐ My son/daughter is taking medications at present. He/she will bring all necessary medications and all medications will be well labeled. The names of and concise directions for taking such medications, including dosage and frequency of dosage are as follows: _____

_____

Signature _____ **Date** _____

☐ No medication of any type whether prescription or nonprescription may be administered to my child unless the situation is life threatening and emergency treatment is required.

Signature _____ **Date** _____

☐ I hereby grant permission for general first aid to be administered, or for nonprescription self-administered medication (such as throat lozenges, cough syrup, Acetaminophen/Tylenol or Ibuprofen/Advil), to be given to my son/daughter, if requested by my son/daughter and deemed advisable by an adult chaperone.

Signature _____ **Date** _____

☐ I wish to inform you of the following additional medical information and the recommended course of action (allergies, dietary restrictions, special conditions, etc.) _____

_____

Signature _____ **Date** _____

☐ I would like to have a member of the DIOCESAN staff speak with me further regarding a medical concern or situation. Please contact me at (_____)_____.(Check ONLY if you need to discuss a medical concern further.)

NOTARY (REQUIRED) City/County of _____; State of _____

On this _____ day of _____, 2019, before me personally appeared the adult named hereinabove, who is personally known to me or produced positive identification, and who executed the foregoing Individual Registration/Medical Permission Form, and acknowledged that he/she executed the same as his/her free act and deed.

[NOTARIAL SEAL]

Signature of Notary Public _____

My commission expires _____