



HOLYTRINITYPTC.ORG • 770-487-0175

**IMPORTANT INFORMATION**  
Please print clearly and fill out all blanks.

STUDENT NAME		
DATE OF BIRTH	AGE	GENDER
PARENT/GUARDIAN		
PARENT CELL	PARENT HOME	
EMERGENCY CONTACT		
PHONE	RELATIONSHIP	
MEDICAL INSURANCE CARRIER		
POLICY HOLDER	RELATIONSHIP	
POLICY NUMBER	GROUP NUMBER	
ALLERGIES	MEDICAL ISSUES/CONCERNS	

**CONSENT AND LIABILITY WAIVER**

I, (Parent/Guardian above), grant permission for my child, (Student above), to participate in this parish event that requires transportation to a location away from the parish site. This activity will take place under the guidance and direction of parish employees and/or volunteers from the parish. A brief description of the activity follows:

**Title of Event:** Parent Night Out

**Date of Event:** February 13, 2011

As a parent and / or legal guardian, I remain legally responsible for any personal actions taken by my child. I agree on behalf of myself, my child named herein, or our heirs, successors, and assigns, to hold harmless and defend this **PARISH** (Holy Trinity Catholic Church), its officers, directors, and agents and the **ARCHDIOCESE OF ATLANTA**, Georgia, chaperones, or representatives associated with the event, arising from or in connection with my child attending the event or in connection with any illness or injury or cost of medical treatment in connection therewith, and I agree to compensate the parish, its officers, directors and agents, and the Archdiocese of Atlanta, chaperones, or representatives associated with the event for reasonable attorney's fees and expenses arising in connection therewith.

I / We hereby grant permission for publication of photos/videos taken at youth events. I give permission for pictures and videos of my son/daughter to be used for promotional materials (both in print and on the web).

**MEDICAL TREATMENT**

In the event of an emergency, I hereby give permission to transport my child to a hospital for emergency medical attention. I wish to be advised prior to any further treatment by the doctor and hospital. If you are unable to reach me, contact the emergency contact listed above.

If you are unable to reach parent/guardian or the emergency contact person, I hereby grant permission for the doctor and hospital to exercise professional judgment in treating student.

I hereby grant permission for non-prescription medications to be given, if deemed appropriate.

All medications (prescription and non-prescription) brought by my student must be checked in on the day of the event.

PARENT/GUARDIAN SIGNATURE

DATE