



**DIOCESE OF SOUTHEAST FLORIDA  
MEDICAL RELEASE AND PERMISSION FORM**

For your information, we expect each student to conform to these rules of conduct

- No possession or use of alcohol, drugs, or tobacco
- No students can drive
- No fighting, weapons, fireworks, lighters, or explosives
- No offensive or immodest clothing
- No boys in girls' sleeping quarters and no girls in boys' sleeping quarters
- Participation with the group is expected
- Respect property
- Respect one another, staff, and adult leaders
- Respect and comply with event schedules

Students who fail to comply with these expectations may be sent home at their parents' expense.

I, the student, have read the rules of conduct, the above evaluation of my health, and permission to participate in youth group activities. I agree to abide by the stated personal limitations and code of conduct.

Student signature: \_\_\_\_\_ Date: \_\_\_\_\_

Activities may include, but are not limited to: cookouts, boating, water skiing, swimming, basketball, roller skating, rollerblading, games in the park, soccer, broomball, ice skating, volleyball, softball, baseball, camping, downhill skiing, snowboarding, hiking, biking, concerts, Bible studies, golfing, miniature golf, hayrides. *Note: If you desire to limit your child's participation in any event, please submit your wishes in writing to the diocesan youth missionary prior to that event.*

\_\_\_\_\_ has my permission to attend all youth activities  
sponsored by \_\_\_\_\_ (hereinafter the Church\*) from  
\_\_\_\_\_ to \_\_\_\_\_  
DATE DATE

This consent form gives permission to seek whatever medical attention is deemed necessary, and releases the Church and its staff of any liability against personal losses of named child.

I/We the undersigned have legal custody of the student named above, a minor, and have given our consent for him/her to attend events being organized by the Diocese. I/We understand that there are inherent risks involved in any ministry or athletic event, and I/we hereby release the Church, its pastors, employees, agents, and volunteer workers from any and all liability for any injury, loss, or damage to person or property that may occur during the course of my/our child's involvement. In the event that he/she is injured and requires the attention of a doctor, I/we consent to any reasonable medical treatment as deemed necessary by a licensed physician. In the event treatment is required from a physician and/or hospital personnel designated by the Church, I/we agree to hold such person free and harmless of any claims, demands, or suits for damages arising from the giving of such consent. I/We also acknowledge that we will be ultimately responsible for the cost of any medical care should the cost of that medical care not be reimbursed by the health insurance provider. Further, I/we affirm that the health insurance information provided above is accurate at this date and will, to the best of my/our knowledge, still be in force for the student named above. I/we also agree to bring my/our child home at my/our own expense should they become ill or if deemed necessary by the student ministries staff member.

Parent/guardian signature: \_\_\_\_\_ Date: \_\_\_\_\_

Diocese of Southeast Florida  
525 NE 15 St.  
Miami, FL 33132  
(305) 373-0881 - (800) 268-9993  
Contact person: Mary Cobiella, ext. 29

**Diocese of Southeast Florida**  
**Medical Release and Permission Form**

**\*Your child may not have or take any medication on his/her own.**

Name of Student \_\_\_\_\_ Grade \_\_\_\_\_  
Age \_\_\_\_\_

Treatment Plan (completed by physician)

Physician: \_\_\_\_\_ Date: \_\_\_\_\_

Past Medical History- Illnesses, Surgeries, Hospitalization

Behavioral Disorders and prescribed  
medication \_\_\_\_\_

Medication(s) (including dosages and frequency)

Special instructions for administration (if applicable) \_\_\_\_\_

Possible side effects (if applicable) \_\_\_\_\_

**\* All prescribed medication and over-the-counter medications must be in the original container with the correct name, date, instructions and physicians name on the label.**

Physician's Signature \_\_\_\_\_ Fax# \_\_\_\_\_

Physician's Emergency Contact # \_\_\_\_\_

Physician's Address \_\_\_\_\_

Parent/Guardian Home# \_\_\_\_\_ Work# \_\_\_\_\_ Cell# \_\_\_\_\_

Or other emergency contact # \_\_\_\_\_

**Parental Permission (or Legal Guardian)**

**I hereby grant my permission to the designated Dioceses personnel to administer the above medication and/or non-prescription medication (such as cough medication, Tylenol, etc.) to my son/daughter.**

Name of Student \_\_\_\_\_

Signature of Parent/Guardian \_\_\_\_\_

Date \_\_\_\_\_