**EMERGENCY MEDICAL/PERMISSION FORM-Diocese of Grand Island, NCYC 2017 Pilgrimage**

***This form is required by all youth participants***

**This release is effective from November 15, 2017 until November 19, 2017.**

I/We, _____ (names), as the parents/legal guardian of _____ (name), a minor residing at the address below, understand this form is in effect at all times while the minor is in care of the **Diocese of Grand Island.** I hereby grant the Diocese of Grand Island and their staff of the **National Catholic Youth Conference** program permission to transport this minor to an emergency medical or health care facility for immediate treatment and/or consultation, if deemed necessary. I/We understand that I/we will be notified of any emergency situation immediately. I/We give authorization to the attending physician, dentist, or medical personnel for any required immediate treatment in the event that I/we cannot be reached at the time of the emergency. I/We agree to be financially responsible for any and all medical expenses and/or treatment costs and all related services provided to the above mentioned minor, and I/we release the **Diocese of Grand Island**, and **National Catholic Youth Conference** staff, from any liability.

I/We understand that this event is sponsored by the **Diocese of Grand Island.** I hereby grant permission for MY/OUR son/daughter to participate in **National Catholic Youth Conference** including transportation to and from event and accept full responsibility for any legal or financial consequences which may result from any personal actions (ie. damage to property or other participants/staff) taken by MY/OUR son/daughter, and I/WE agree to hold the **Diocese of Grand Island** harmless with respect to any actions or claims that may be made in connection with personal actions taken by MY/OUR son/daughter. I/We also grant the **Diocese of Grand Island** permission to use photos and video of my child for publicity purposes.

I/We authorize the release of information to my/our insurance company and family physician:

Insurance Company Name: _____
Address: _____
Phone: _____ Policy #_____
Physician's Name: _____
Address:_____
Phone: _____

I have the following allergies (**including food allergies):**

_____
_____
_____

I have the following medical conditions (**including mental health or pregnancy**):

_____
_____
_____

I am currently taking the following medications:

_____
_____
_____

Please check:

___ I prefer that she/he be responsible for these medications her/himself.
___ I prefer that the staff hold these medications and dispense according to the directions.
**___ I do ___ I do not** give permission for this minor to be given over-the-counter treatments (such as Tylenol, Tums, Sudafed, etc.) if she/he experiences discomfort and requests treatment.

_____ Date: _____
(Signature of parent(s)/legal guardians)
Address: _____
Home Phone: _____ Town: _____ Zip: _____
Work Phone: _____ (ask for _____)
Work Phone: _____ (ask for _____)