Youth & Young Adult Ministry and CYO Office

2009 National Catholic Youth Conference

MEDICAL AUTHORIZATION

In the event reasonable attempts to contact me at _________________________ (phone #) or _____________________ (other parent) at __________________ (phone #) have been unsuccessful, I hereby give my consent for: 1) the administration of any treatment deemed necessary by Dr. __________________________ (preferred physician) at ______________________ (phone #), or Dr. __________________________ (preferred dentist) at ____________________ (phone #), or in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and 2) the transfer of my son/daughter to ______________________________ (preferred hospital) or any hospital reasonably accessible. This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained before surgery is performed.

AUTHORIZATION TO PHOTOGRAPH & RELEASE I hereby **(please check one) _ give _do not give** permission and authorize Catholic Charities Health & Human Services (hereinafter "CCHHS"), its agents, employees, successors and assigns to photograph, or otherwise electronically or digitally record my image (or the image of the minor child for whom I am parent or legal guardian) for publication in printed or electronic form, and for my image (or that of my minor child) to be seen and disseminated to the general public in any media form, including, but not limited to a CCHHS newsletter, poster, display, film, video or website.

In consideration of my/my child's participation in a CCHHS program, and wishing to promote and benefit this non-profit cause, I hereby release and hold harmless CCHHS, any of its related corporate entities, the Bishop of the Roman Catholic Diocese of Cleveland, the Roman Catholic Diocese of Cleveland, their representatives, licensees, agents, employees, successors and assigns, from any and all liability for claims and demands arising out of the use of my image in any aforementioned media. I specifically waive any rights and claims that I may have or claim for privacy, invasion of privacy, libel, payment or royalties for use of the above-described photograph, as well as any other claims for damages or other relief in law or equity.

I fully understand what is involved in this experience and the foregoing forms, and I understand I have the opportunity to call the Youth & Young Adult Ministry and CYO Office (216-334-1261 x28), with any questions I may have.

_____________ _______________________________

(Date) (Parent/guardian signature)

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Refusal to Consent

I do not give my consent for emergency medical treatment of my son/daughter. In the event of illness or injury requiring emergency treatment, I wish the youth ministers to take no action or to:

____

____

I fully understand what is involved in this experience and the foregoing form, and I understand I have the opportunity to call the Youth & Young Adult Ministry and CYO Office (216-334-1261 x28), with any questions I may have.

_____________ _______________________

(Date) (Parent/guardian signature)

Due date: June 29, 2009

Mail to: Youth & Young Adult Ministry and CYO Office, Attn: NCYC Registration
7911 Detroit Avenue, Cleveland, OH 44102

Form D - NCYC Medical Information/Authorization Form - Diocese of Cleveland

Must Be Completed For All Youth, Young Adults and Adults Attending

Each participant must keep a copy of this form inside their name badge at all times

(Please Print)
Name of Participant: First: ___________ Middle: __________Last: _________
Male Female
Select One: Adult (21 or older) Young Adult Assistant (18-20) Youth (in H.S.)
Date of Birth (mm/dd/yy): ____/____/____

List only the Parent/Guardian(s) with whom participant resides:
Name of Parent/Guardian: First: ___________ Middle: __________Last: _________
(for Youth only)
Home Address: ____
City, State, Zip:____________________, _______, ___________County ___________
Home Telephone: _____/_____-_______ Work Telephone: _____/_____-_______

Medical Information

Family Doctor: __________________ Telephone: _____/_____-_______
Family Dentist: __________________ Telephone: _____/_____-_______
Family Health Plan Carrier: ____
Policy Number: _____________________

Specific Medical Information

Youth & Young Adult Ministry and CYO Office will take reasonable care to see that the following information will be held in confidence.

Allergic Reactions (medications, foods, plants, insects, etc.)

Immunizations: date of last tetanus / diphtheria immunization)

Medications child currently takes

Does child/adult have a medically prescribed diet?

Any physical limitations

Is child subject to chronic homesickness, emotional reactions to new situations, sleepwalking, bedwetting, fainting?

Has child/adult been exposed to contagious disease or condition, such as mumps, measles, chicken pox, etc.? If so, date and disease or condition.

You should also be aware of these medical conditions of the child/adult.

Special medical conditions, continued…