ST. AMBROSE Kolbe's Kids

Emergency Phone # of parents/Guardian (___) ____ -_____

As the parent/legal guardian of: _____

Permission is hereby given for my child to participate in Kolbe's Kids on Mondays September 24th, 2018 - Mayfrom 3:30-4:45pm in the Parish Hall Library at St. Ambrose Catholic Church. Kolbe's Kids activities will include praying the Rosary, doing service projects and enjoying Oreos while growing in faith and friendship with our Lady, the Blessed Mother. If you have any questions or would like to help out, contact me at cym@stambroseva.org.
God bless,
Therese Ryan

Parental Permission and Liability Release: As parent/legal guardian of the participant named above, I give my permission to participate fully in Kolbe's Kids on Monday afternoons from September 11th, 2017-May 20th , 2019 from 3:30-4:45pm in the Parish Hall Library at St. Ambrose Catholic Church. I agree to indemnify and hereby release the Most Reverend Michael F. Burbidge, Bishop of the Catholic Diocese of Arlington and his successors in office, as well as the Catholic Diocese of Arlington and all Diocesan clergy, employees, volunteers, and participating parishes and schools from any and all liability, claims, demands for personal injury, sickness and death, as well as property damage and expenses of any nature whatsoever which may be incurred by the undersigned of the participant resulting from said participant's involvement in the above described event.
Informed Consent to Medical Treatment: I request that in my absence the above-named minor be admitted to any hospital or medical facility for diagnosis and treatment. I request and authorize physicians, dentists, and staff, duly licensed as Doctors of Medicine or Doctors of Dentistry or other such licensed technicians or nurses, to perform any diagnostic procedures, treatment procedures, operative procedures and x-ray treatment of the above minor. I have not been given a guarantee as to the results of examination or treatment. I authorize the hospital or medical facility to dispose of any specimen or tissue taken from the above-named minor. I assume full responsibility for all costs of such treatment. Further, should it be necessary for the participant to return home due to medical, disciplinary, or other reasons, I do hereby assume responsibility for the participant's transportation home and any costs related thereto.

Photo, Press, Audio: I authorize the Catholic Diocese of Arlington, its parishes, its schools and/or the Arlington Catholic Herald to use and publish my child's photograph, video and/or audio recording along with their name identifying them for educational, news stories, illustration and/or marketing purposes. At the above mentioned event (including transportation to and from the event).

Electronic Media Release: Furthermore, I on behalf of the participant hereby assume all risk of personal injury, sickness, death, damage, and expenses resulting from said participant's

involvement in the above described event. Informed Consent to Medical Treatment: I request that in my absence the above-named minor be admitted to any hospital or medical facility for diagnosis and treatment. I request and authorize physicians, dentists, and staff, duly licensed as Doctors of Medicine or Doctors of Dentistry or other such licensed technicians or nurses, to perform any diagnostic procedures, treatment procedures, operative procedures and x-ray treatment of the above minor. I have not been given a guarantee as to the results of examination or treatment. I authorize the hospital or medical facility to dispose of any specimen or tissue taken from the above-named minor. I assume full responsibility for all costs of such treatment. Further, should it be necessary for the participant to return home due to medical, disciplinary, or other reasons, I do hereby assume responsibility for the participant's transportation home and any costs related thereto.

Emergency Contact: Name_____ Relationship: _____ Phone Number: (H) _____ (W) _____ (C) _____ Health Information: Are there any medical conditions which may affect the participant's involvement in the above event?

_____

Allergies including any allergies to medicine? _____

ListMedications:_____

Physician and Medical Insurance: Primary Healthcare Provider _____

Phone _____ Insurance Company _____

Policy Number: _____

I understand and hereby agree to the terms and conditions of the participant's involvement in the above described event and I freely execute this Acknowledgement with full knowledge of its content. Participant's Name (Please print) Home Phone Address City/State/Zip Parent's Name Mobile Phone Work Phone Signature of Participant Date Signature of Parent or Legal Guardian Date

Parent Signature:

_____Date:_____

Safety: As the participant, I agree to follow all procedures, safety precautions, and rules and regulations set forth by the Diocese and the Parish.

Participant Signature:

_____Date:_____