MEDIA CONSENT FORM

Parish_____Youth Ministry programs engage in various correspondence and publicity with families, parishioners and other members of the community regarding various aspects of this program. Parents are given the option of authorizing the use of their children's photos with or without names for those purposes, if they so desire.

If you wish to provide authorization, please complete the information below, and provide it to the parish Coordinator of Youth Ministry.

Parish Name_____**City**_____

Student's Name	Grade	Date of Birth

Parents may cancel this Authorization at any time by providing written notice to the Parish at (address of Parish Religious Education Program)

Video/Photography Utilization

(1) I give permission for my child to be photographed or videotaped for educational and community relations not-for-profit use such as newsletter articles, [Insert name of parish] paper or parish bulletin, community newspaper articles, website, etc.

Signatures:

By: _____ Date _____
(Signature of Parent or Guardian)

Name: _____
(Printed - Parent or Guardian)

(2) In addition, I give permission for my child's **name** to accompany my child's photo or video be published for community relations/PR purposes, etc.

Signatures:

By: _____ Date _____
(Signature of Parent or Guardian)

Name: _____
(Printed - Parent or Guardian)

EMERGENCY MEDICAL TREATMENT RELEASE FORM

To Whom It May Concern:

As parent/guardian, I do hereby authorize the treatment of a qualified and licensed Medical Doctor in an emergency which, in the opinion of the attending physician, may endanger his/her life, cause disfigurement, physical impairment, or undue discomfort if delayed. This authority is granted only after a reasonable effort has been made to reach me.

Student's Name: _____ Relationship to you: _____

Address: _____ Phone: _____

Type of activity or school year for which release is intended: _____

PARENTS/LEGAL GUARDIANS

_____

Father Address Phone

_____

Mother Address Phone

Where parents can be reached when not at home:

Father_____
Address Phone

Mother_____
Address Phone

Family Physician: _____Phone:_____

Address:_____City:_____

List allergies, medication, or other pertinent comments:

_____

_____

Health Insurance Data:

Company: _____ Policy: _____

Group: _____ Contract: _____

List a neighbor or close relative who will assume care of your child if you cannot be reached.

Name _____ Phone _____

Address _____ Relationship _____

This release form is completed and signed of my own free will with the sole purpose of authorizing medical treatment under emergency circumstances in my absence.

Date: _____ Signed: _____
(Parent or Guardian)

Attention Parents: **This form should be notarized.**
Some medical facilities will only provide treatment if the signature is notarized.

NOTARY TO COMPLETE:

State of: _____
County of: _____

Subscribed and sworn to before me
This _____ day of _____, _____
_____ Notary Public

August 1998