Office Use Only:
Athletic Fee _____
Cash ____ Check #_____
Date Paid _____

Archdiocese of Las Vegas

Athletic and Sporting Events

Parent/Guardian Consent Form and Liability Waiver

Participant's name: _____

Birth date: _____ Sex: _____

Parent/Guardian name: _____

Home address: _____

Home phone: _____ Business phone: _____

I/We, _____, grant permission for my child, _____
Parent /Guardian name Child's name

to participate in this Parish/School/Institution activity that may require transportation to a location away from the Parish/School/Institution site. This activity will take place under the guidance and direction of Parish/School/Institution employees and/or volunteers from

St, Viator School. A brief description of the activity follows:
Parish/School/Institution

Type of event: Cross Country

Date of event: See page 3
(If there is more than one activity scheduled see page 3)

Location: SVS gym and school events/games see page 3

Individual in charge: Matt Lisowski

Duration of activity: See page 3

Mode of transportation to and from event: See page 3

As parent and/or legal guardian, I/we remain legally responsible for any personal actions taken by the above named minor (participant).

I/We agree on behalf of myself, my child named herein, or our heirs, successors, and assigns, to hold Harm-less The Roman Catholic Bishop of Las Vegas, and His Successors, A Corporation Sole (The Diocese of Las Vegas), and defend its officers, directors and agents, and coaches, chaperons, volunteers, representatives and St. Viator School
(Name of the Parish/School/Institution)
associated with the event, from any and all liability, arising from or in connection with my child attending the event or in connection with any illness or injury or cost of medical treatment in connection therewith, and I agree to compensate the Parish/School/Institution, its officers, directors and agents, and the Roman Catholic Bishop of Las Vegas, and His Successors, A Corporation sole (The Diocese of Las Vegas), coaches, chaperons, volunteers or representatives associated with the activity for reasonable attorney fees and expenses arising in connection therewith.

Signature: _____ Date: _____

Print name: _____

Medical Matters: I hereby warrant that to the best of my knowledge, my child is in good health, and I assume all responsibility for the health of my child. (Of the following statements pertaining to medical matters, sign only those that are applicable).

Emergency Medical Treatment: In the event of an emergency, I hereby give permission to transport my child to a hospital for emergency medical or surgical treatment. I wish to be advised prior to any further treatment by the hospital doctor. In the event of an emergency, if you are unable to reach me at the above numbers, contact:

Name & relationship: _____ Phone: _____

Name & relationship: _____ Phone: _____

Family doctor: _____ Phone: _____

Family health plan carrier: _____ Policy: _____

Signature: _____ Date: _____

Other Medical Treatment: In the event it comes to the attention of the Parish/School/Institution, its officers, directors and agents, and the Roman Catholic Bishop of Las Vegas, and His Successors, A Corporation Sole (The Diocese of Las Vegas), coaches, chaperons, volunteers or representatives associated with the activity that my child becomes ill with symptoms such as headache, vomiting, sore throat, fever, diarrhea, I want to be called collect (with phone charges reversed to myself).

Signature: _____ Date: _____

Medications: My child is taking medication at present. My child will bring all such medications necessary, and such medications will be well labeled. Names of medications and concise directions for seeing that the child takes such medications, including dosage and frequency of dosage, are as follows:

_____

Signature: _____ Date: _____

No medication of any type, whether prescription or non-prescription, may be administered to my child unless the situation is life threatening and emergency treatment is required.

Signature: _____ Date: _____

I hereby grant permission for non-prescription medication (such as acetaminophen, throat lozenges, cough syrup) to be given to my child, if deemed appropriate.

Signature: _____ Date: _____

Specific Medical Information: The Parish/School/Institution 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: _____

Does child have a medically prescribed diet? _____

Are there any physical limitations? _____

Has your child recently been exposed to a contagious disease or conditions such as mumps, measles, chickenpox, etc.? If so, data and disease or condition: _____

You should be aware of these special medical conditions of my child: _____

_____

_____

_____

Multiple Activities Schedule

Date	Activity	Location	Depart/Return	Mode of Transportation
Mondays & Wednesdays **September:** 14, 16, 21, 23, 28, 30 **October:** 5, 7, 12, 14, 19, 21, 26, 28 **November:** 2, 4	Practice	UNLV Track	3:15pm-4:15pm	Parent
Saturdays **September:** 12, 19, 26 **October:** 3, 10, 17, 24, 31	Practice	Paradise Vista Park	9:00am-10:15am	Parent
November 6	Cross Country Meet	SFDS	TBD	Parent

Signature:_____ Date:_____

Print name:_____

The Multiple Activities Schedule may be used for a sport that involves multiple trips during a season, such as: Football, Basketball, etc.