

GUARDIAN ANGELS CHURCH PERMISSION FORM AND MEDICAL RELEASE FORM

Participant's Name: _____

Birth Date: _____ Gender: _____ Grade in 2025/26 _____

Parent/Guardian's Name: _____

Home Address: _____

Home Phone: _____ Cell Phone: _____

Parent E-mail address _____

Date/Type of Event: Confirmation preparation, Sunday's (please see dates on the overview)

Destination: Guardian Angels Catholic Church, Youth Room

I, _____, grant permission for _____
(Parent or guardian's name) (Child's name)

to participate in the above-named activity and I warrant that my child is in good health. In consideration of my child's participation, I agree to indemnify Guardian Angels and the Archdiocese of St. Paul/Minneapolis from any claims or lawsuits brought against Guardian Angels Archdiocese of St. Paul/Minneapolis by myself, my child or others, that arises out of any behavior by my child at the event/activity described above. I also agree to pay reasonable attorney's fees or expenses incurred by Guardian Angels and Archdiocese in defense of such a claim/lawsuit.

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

Name: _____ Phone number: _____

MEDICAL INFORMATION:

Medication my child is taking at present: _____

Family Health Plan carrier name: _____

Family Doctor: _____ Phone number: _____

As parent or guardian, I agree to all of the above stated considerations and conditions.

(Signature)

(Date)