

St. Gabriel the Archangel Catholic Church  
6000 West 34<sup>th</sup> Street, Indianapolis, IN 46224  
Youth Ministry Registration Form  
2009-2010 Program Year

Youth Name: \_\_\_\_\_

Grade: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- I hereby give permission for my child (ren) to participate in St. Gabriel Youth Ministry program and to attend functions sponsored by St. Gabriel Youth Ministry on or off the premises of St. Gabriel Church.
- I accept, to the best of their ability, that the program director and/or event sponsor will provide a safe environment.
- I hold my child (ren) responsible for their own actions and expect they will follow the rules and guidelines established. If an unforeseen situation occurs, I release the Archdiocese, St. Gabriel the Archangel parish, the pastor, director, employees, and volunteers from all liability for any harm or damages.
- I understand that my child (ren) is expected to act in accordance to the following Youth Code of Conduct and if deemed not, I may be called and asked to remove my child (ren) from the event.
- I hereby grant the irrevocable and unrestricted right to use and publish photographs taken at a youth ministry activity or event of me or my family, for editorial and advertising purposes.

**Youth Code of Conduct**

- + All participants are expected to demonstrate common courtesy and respect at all time. Inappropriate language/behavior will not be tolerated.
- + Socializing should always been done in public areas.
- + Dress should reflect the value of modesty. Writing on clothing should reflect Christian values.
- + **The possession or consumption of any alcoholic beverage and/or possession/use of any illegal drug by an individual is not permitted.**
- +Smoking is not permitted.
- +Weapons and drug paraphernalia are not allowed.
- + Infraction of these rules can mean immediate dismissal with no refund. Participants are also responsible to local authorities as well.

*I understand and agree to this behavior code. I also understand and agree that at anytime of an infraction requiring my dismissal, I am responsible for my removal from the premises and any costs involved.*

**Youth Signature:** \_\_\_\_\_ **Date** \_\_\_\_\_

**Youth Signature:** \_\_\_\_\_ **Date** \_\_\_\_\_

**Youth Signature:** \_\_\_\_\_ **Date** \_\_\_\_\_

**Parent/Guardian Signature:** \_\_\_\_\_ **Date** \_\_\_\_\_

Please complete the attached **CONTACT AND EMERGENCY INFORMATION FORM AND RETURN WITH THIS PERMISSION FORM**. Note: The attached **PARENT/GUARDIAN RELEASE SELF-ADMINISTRATION OF MEDICATION FORM** MUST BE ON FILE IF THE CHID IS TO RECEIVE MEDICATION AT ANY TIME DURING AN EVENT.

Saint Gabriel the Archangel Catholic School and Parish  
**CONTACT AND EMERGENCY INFORMATION FORM**

IDENTIFYING INFORMATION				EMERGENCY CONTACT INFORMATION		
Full Legal Name of Child:				<i>In the case of emergency or serious illness of my minor child, please attempt contact in the order listed below:</i>		
Birthdate:		Grade:		Call 1 <sup>st</sup> :	Name:	Home/Work Phone:
Parent (Guardian) Names:					Relationship:	Cell: Phone:
Address Street:				Call 2 <sup>nd</sup> :	Name:	Home/Work Phone:
Address Apartment No./Other:					Relationship:	Cell: Phone:
Address City:		State:	ZIP:	Call 3 <sup>rd</sup> :	Name:	Home/Work Phone:
Home Phone:		E-mail Address(es):			Relationship:	Cell: Phone:
Child lives with: <input type="checkbox"/> Mother and Father <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Grandparent(s) <input type="checkbox"/> Guardian				Local Hospital of Choice:		
Who is the Custodial Parent (if applicable)?			<input type="checkbox"/> Custody Papers on file?	Physician of Choice:		Phone:
Siblings attending this (school, program, event):				HEALTH INSURANCE INFORMATION		
Adults authorized to pick up my child:	Name:		Phone No.	Company:		Co. Phone:
				Policy Holder		Group No.:
				Holder ID No.:		Plan No.:
				Policy No.:		Patient (Child) ID No.:
MEDICAL INFORMATION						
<b>Child's Medical Conditions:</b>	Please list below any medical conditions your child has such as chronic or serious illness; severe allergies or sensitivities including, but not limited to: food, medicine, insects, or heat; asthma; cancer; diabetes, heart condition; respiratory problems; seizures, urinary problems; hemophilia; frequent hospitalizations; vision or hearing difficulties, physical limitations, etc. <input type="checkbox"/> Individual Health Plan for chronic conditions on file (if applicable)			<b>Medications Taken Regularly by Child:</b>	Please list below any medications, treatments, or medical care your child receives on a regular basis that medical personnel may need to know about at the time of treatment for illness or injury.  <input type="checkbox"/> Medication Release on file for all medications taken at (school, program, event, trip)	
CONSENT TO MEDICAL TREATMENT FOR A MINOR CHILD						
<p>I understand that in the case of a serious medical emergency, unless the injury/illness appears to be immediately life-threatening, the staff will make reasonable attempts to contact me/us as specified above <i>before</i> authorizing medical treatment. If I/we are not available to give consent, I/we hereby authorize the staff of (school, parish, or archdiocesan program) to act on my/our behalf, to call 911 emergency services, transport by ambulance, hospitalize; secure proper treatment; authorize injections, anesthesia, x-ray, surgery or other treatment for my child as deemed necessary by qualified medical personnel. I also understand that the medical information provided will be shared only on a medical "need-to-know" basis among staff and with treating medical personnel.</p> <p><b>Notice is hereby given</b> to qualified medical personnel that this authorization is currently in effect, and such personnel are directed to act upon this authorization without delay. I/we agree to assume financial responsibility for all expenses incurred in any emergency requiring medical attention.</p>						
Parent/Guardian Signature(s):			Relationship(s):		Date:	

Saint Gabriel the Archangel Catholic School and Parish

**PARENT/GUARDIAN RELEASE  
SELF-ADMINISTRATION OF MEDICATION**

Archdiocese of Indianapolis Policy Statement 2008-02 recognizes that parents (guardians) have the primary responsibility for the health of their children. Although it is strongly recommended that medication be administered in the home, the health of some children and youth may require that they receive medication or other medical care while in the care of (*name of school or program*).

If a (*child/youth/student*) must take medicine while at (*school, parish or archdiocesan program*) please be advised of the following:

Parents (guardians) should confer with their medical practitioner to arrange medication intervals to avoid administration of medication outside the home whenever possible.

When medication absolutely must be taken at other times outside the home, parents (guardians) shall provide explicit written instructions including, in some cases, instructions as necessary from a medical practitioner regarding the need for medication or specific medical care.

Parents (guardians) signing this form are, in most cases, providing written permission for **non-medically trained personnel** to oversee the **self-administration** of medication or necessary routine medical care **by the (*child, youth, student*)** depending upon age and capability.

Medical circumstances requiring the direct measuring and/or administration of medications, injections, blood tests, observation of symptoms, specific emergency responses by non-medically trained staff personnel or the possession and use of inhalers or other medical devices, shall be handled on a case-by-case basis according to a specific Individual Health Plan developed and signed by a physician or other health care professional and kept on file for the (*child/youth/student*).

(*Children/Youth/Students*) are not permitted to carry medications (including analgesics, herbs, enzymes, oils, etc.) on their persons, except for inhalers and other medical devices with specific permission. Medications will be secured in (*the office, with the director, trip leader*).

All medication is to be delivered and taken home by the parent (guardian) at the end of the medical regimen or (*school year/program/event, trip*) (*Change: High school age youth may deliver and take home medicine with advance parent [guardian] permission*).

All medication is to be taken in the presence of a designated staff member and documented in a confidential log.

**No medication** of any kind is to be provided by the (*school, parish, archdiocesan program*), staff or volunteer personnel.

Prescription medication must be in the original pharmaceutically dispensed and labeled container. The prescription label will be considered the written order of the medical practitioner in most cases.

Non-prescription medication must be in the original container in which it was purchased. Please provide medicine cups/spoons as necessary for liquid medication.

Parents must fill out, sign and date a new form for each medication or to change medication instructions (*and/or for each event/trip*).

All medication releases must be renewed at the beginning of each (*school/program*) year (*or for each trip/event*).

Please provide specific written instructions below for administration of medication during (*school, program hours, event/trip*):

Name of ( <i>child/youth/student</i> ): ( <i>may add other necessary ID information</i> )	
Name of medication: <input type="checkbox"/> Prescription <input type="checkbox"/> Non-Prescription <input type="checkbox"/> Refrigeration Required	
Diagnosis/reason the medication is to be taken:	
The appropriate dose, method of administration (i.e., by mouth) and specific instructions (i.e., take with food, etc.):	
The time or times of day (hours) medication should be taken in our care:	
The start date and number of days/weeks/ months the medication is to be taken:	
Any known side-effects of the medicine and/or symptoms of the condition being treated and known tolerance to medicine:	

I hereby give permission for non-medical staff personnel to oversee self-administration of the medication specified above by my child: Parent (Guardian) Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Emergency Phone Number: \_\_\_\_\_