

**PERMISSION TO PARTICIPATE &
MEDICAL RELEASE**

I hereby give permission for my child, _____ Grade _____ to participate in the **Halloween Haunted House 2005** activities sponsored by St. Patrick Youth Ministry Program. Please see attached sheet for specific dates of meeting. (If your child will not be able to attend a meeting, please write a letter to Beverly Pascua or contact her at 510-799-4434.) I understand that these activities will be supervised by adults, but that neither St. Patrick nor the volunteer supervisors and chaperones can be held responsible for any accident which may occur.

In case of emergency, I can usually be contacted at:

Parent's Name _____ Phone/work/cell# _____

If I am unavailable, contact:

Name _____ Phone/work/cell# _____

In the event that I cannot be reached, I give permission for an adult leader from St. Patrick Youth Ministry Program to authorize appropriate medical treatment for my child. This authorization will remain in effect until November 2005, unless sooner revoked in writing and delivered to St. Patrick Church.

Family Physician _____

Address _____ **Phone** _____

Medical Plan _____ **Plan No** _____

List all conditions (such as allergies, seizures) for which your child requires ongoing medication and state the type and frequency of medication given:

Has your child had difficulty with the following (circle all that apply):

Asthma	Fainting Spells	Convulsions	Diabetes	Heart	Eyes
Ears	Nose	Throat	Lungs	Digestion	
Menstrual Problems	Other _____				

List any physical restriction for any activity on the basis of medical condition:

Allergy or reaction to any medication or food? No Yes, List _____

State the date of your child's last physical examination: _____

I have read this Agreement and understand everything written above.

Signature of Parent or Guardian _____
Date