

**Confirmation Program Release and Consent**

~ Please Print ~

Candidate name: \_\_\_\_\_ Birth date: \_\_\_\_\_ Age: \_\_\_\_\_  
Name of Parent(s)/Guardians: \_\_\_\_\_  
Address: \_\_\_\_\_  
Home phone: \_\_\_\_\_ Emergency Phone: \_\_\_\_\_

I, \_\_\_\_\_ (parent/legal guardian), the undersigned, give my permission for my son / daughter, \_\_\_\_\_, to participate in St. George Parish Confirmation Program and Service Experiences. These activities will take place under the guidance of an individual(s) who has completed a CORI for the Diocese of Worcester.

While youth are responsible for their own behavior, as parent and /or legal guardian, I remain legally liable for any actions or damages made by my child. I have instructed the above named minor to be respectful toward all adult leaders and to conduct themselves in a Christian manner.

I hereby warrant to the best of my knowledge, my child is in good health and I assume all responsibility for the health of my child. In the event of medical emergency and if I (or other below named guardian) cannot be reached, I hereby give permission to transport my child to a hospital or medical facility and to seek medical attention. In case of emergency, please contact (Please list primary guardians and one alternate contact.):

1. Name \_\_\_\_\_ Phone \_\_\_\_\_
2. Name \_\_\_\_\_ Phone \_\_\_\_\_
3. Name \_\_\_\_\_ Phone \_\_\_\_\_

In the event of **urgent medical emergency** and if none of the above named contacts can be reached, I authorize the necessary medical treatment to be administered by qualified medical personnel for the benefit of my son /daughter. I relieve the Diocese of Worcester, a Corporation Sole, and St. George's Parish of all responsibility and consequences that may arise as a result of this treatment. I will not hold the Diocese or their associated representatives responsible in the event of injury. I also agree to accept all financial responsibility as a result of scheduling such treatment.

The following medical information must be completed:

Insurance Company \_\_\_\_\_  
Group # \_\_\_\_\_  
Subscriber's Name \_\_\_\_\_  
Subscriber's # \_\_\_\_\_  
Employer \_\_\_\_\_

Date of last tetanus shot \_\_\_\_\_

Allergies \_\_\_\_\_

Medications currently taking (name & dosage) \_\_\_\_\_

You should also be aware of these special medical / physical / mental conditions of my child: \_\_\_\_\_

I have read the Program Guidelines attached to this form (initial & circle please)      Yes \_\_\_\_\_

I give my permission to include my child in photos (see next pg. - circle one response please)      Yes                      No

\_\_\_\_\_  
Parent/Guardian's Signature

\_\_\_\_\_  
Date