

MIDDLE SCHOOL MISSION WEEK



WHO: All students entering 6TH-8TH grade in the 2017-18 school year

WHAT: A service experience filled with fellowship, faith, and fun!

Spend a few hours serving in our community and then come back together for time in fellowship and prayer with peers.

WHEN: June 12 – 16, 2017 **TIME:** 12:45 – 4:45 PM

WHERE: Drop-off and Pick-up at St. Martha's Youth Center

Service projects will take place on Tuesday – Friday in the Kingwood-Humble-Atascocita area and will be determined based upon the number of students and drivers committing to the mission week. Monday will be a day of fellowship and preparation for the service projects.

COST: \$40.00*

*\$30 for children of chaperones/drivers

*Spots limited to the **first fifty** students to sign up!*



ATTENTION PARENTS!

In order for this program to work, we need parents to commit to **chaperoning** and **driving**. Please indicate below which days you would be willing to help and then attach that portion to the liability forms. **Thank you in advance!**

There will be a short volunteer meeting on Thursday, June 8 at 6:30 pm in the Youth Center.

Driver's Name: _____

Name of Child: _____

Total Number of Seatbelts in the Vehicle: _____

Cell Phone: _____

T-Shirt Size: _____

Please check the date(s) you can help:

- Tuesday, June 13
- Wednesday, June 14
- Thursday, June 15
- Friday, June 16

**We will return by 4:00 so VBS kids can be picked up*

Archdiocese of Galveston-Houston

St. Martha Catholic Church

Parental/Guardian Consent Form and Liability Waiver

Participant's Name: _____ Date of Birth: _____

Home Address: _____ City: _____ Zip Code: _____

Parent(s)/Guardian(s): _____ Home Phone: (_____) _____

Alternate Phone: (_____) _____ Grade: _____ Age: _____ Sex: _____ [2017-18]

★ E-Mail Address: _____ School: _____

T-Shirt Size (Please Circle One): YL S M L XL XXL

CONSENT AND LIABILITY WAIVER

Important! To be filled out by the Parent/Guardian for youth under 18 years of age. If participant is 18 years of age or older, consent must be signed by the individual.

I (name of parent/guardian) _____, grant permission for my child, (participant's name) _____, to participate in (event) Middle School Mission Week _____ to be held (date) 6/12/17-, (time) 12:45-4:45pm, and (location) Various Service Projects in the Kingwood/Humble Area 6/16/17

In consideration of my child's participation in this event, I agree on behalf of myself, my child named herein, and our heirs, successors, and assigns to indemnify, hold harmless and defend the Archdiocese of Galveston-Houston, the sponsoring parish, its pastor, youth ministry leader, principal, other agents, employees or other representatives associated with the event from any and all injuries, losses or claims arising out of my child's participation in the event.

In signing this form I certify that all information contained herein is true and accurate to the best of my knowledge.

★ _____ Date

Signature (Parent/Guardian)

Date

YOUTH PARTICIPANT: In signing the line below I agree to abide by any/all policies and rules established for this event/activity (see Code of Conduct). Should I not be able to maintain the guidelines and expectations of the adults and my peers, I understand that there will be consequences for my actions, including being removed from the activity and being sent home at my parent's expense.

★ _____ Date

Signature (Youth Participant)

Date

VIDEO/PHOTOGRAPHY CONSENT

As parent/guardian, I understand that promotional pictures (individuals and group) will be taken during this event. I give permission for my child's picture to be used for promotional materials (newsletter, web page, calendars, power point, video, etc.) in highlighting the event.

★ _____ Date

Signature (Parent/Guardian)

Date

See Reverse For Medical Consent

Medical Matters

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. Of the following statements pertaining to medical matters, sign only those in accordance with your wishes.

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 or doctor and I understand that all financial obligations are my responsibility.

In the event of an emergency and you are unable to reach me, contact:

Name & Relationship _____ Phone _____

Family Doctor _____ Phone _____

Medications

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

My child is taking the following medication at the present time.

Medication(s): _____ Dosage _____

Administer: _____

★ **Please choose only one of the following:**

_____ I hereby **Do Not Grant Permission** for medication of any type, whether prescription or nonprescription may be administered by my child unless the situation is life threatening and emergency is required. **(Please initial)**

_____ I hereby **Grant Permission** for nonprescription medication (such as Tylenol, throat lozenges, cough syrup) to be given to my child, if deemed advisable. I understand that Aspirin will not be given to my son/daughter. **(Please initial)**

Medical Conditions Information: *(All personnel will take reasonable care to see that the following information will be held in confidence.)*

My son/daughter has:

- Has had an episode of the following or has been diagnosed: Seizures Asthma Diabetic
- Allergic reactions to the following (foods, dyes, latex, etc.) _____
- Has had a medical surgery within the last six months?: Yes No Still under doctor's care?: Yes No
- Has a medically prescribed diet? _____
- The following physical limitations? _____
- Immunizations current and up to date: Yes No Date of last tetanus/diphtheria immunization: _____
- You should also be aware of these special medical conditions of my child (e.g. depression, anxiety, etc.): _____

Insurance Information: **No, I do not carry medical insurance at this time.**

Insurance Carrier: _____ Name of Insured: _____

Insurance Policy Number: _____

Father's Name: _____ Day Phone: _____

Mother's Name: _____ Day Phone: _____

In the event it comes to the attention of the chaperones associated with the activity that my child becomes ill with the repeated symptoms such as headache, vomiting, sore throat, fever, diarrhea, I want to be called immediately. If this will be a long distance call, I want to be called collect (with phone charges reversed to myself). I fully understand the foregoing statements and sign this Parental/Guardian Medical Consent Waiver knowingly, freely, and willingly.

★ _____

Signature (Parent/Guardian) _____ **Date** _____

Signature (Participant 18 years of age or older must sign own consent) _____ **Date** _____