



# [SERVICE TUESDAYS]

For all students entering 6<sup>TH</sup>-8<sup>TH</sup> grade to spread God's love to the community!

**JULY  
11**

**JULY  
18**

**JULY  
25**

**[9:00 AM – 1:00 PM]**  
**Meet at St. Martha's Youth Center**  
*Students will be organized into small groups to serve at various service sites in the Kingwood/Humble/New Caney area, then return to St. Martha for lunch and fellowship.*

**Bring your lunch or \$3 for Pizza each Tuesday** 

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# ATTENTION PARENTS!

In order for this program to work, we need each parent to commit to **chaperoning and driving** at least one (or more) Tuesdays during the summer. Please indicate below which days you would be willing to help and then attach that portion to the liability forms. **Thank you in advance!**

*Return completed form to the Faith Formation Office*

Driver's Name: \_\_\_\_\_

Name of Child: \_\_\_\_\_

Total Number of Seatbelts in the Vehicle: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

**Please check the date(s) you can help:**

- Tuesday, July 11
- Tuesday, July 18
- Tuesday, July 25

★ Please check the date(s)  Tuesday, July 11  Tuesday, July 18  Tuesday, July 25  
your child plans to attend:

You may add or change dates by e-mailing [lisah@stmartha.com](mailto:lisah@stmartha.com)

**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: \_\_\_\_\_

**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) Service Tuesdays \_\_\_\_\_ to be held  
(date) 7/11/17-, (time) 9:00am – 1:00pm, and (location) Various Service Projects in the Kingwood/Humble Area.  
7/25/17

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.*

★ \_\_\_\_\_  
**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.

\_\_\_\_\_  
**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.

★ \_\_\_\_\_  
**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**