



Diocese of Crookston Youth Conference Parent Permission and Liability Waiver

Last name _____ First name _____ Gender _____
Date of Birth _____ Age _____ Grade in School _____
Parish name _____ Parish City _____
Parent Name _____ Parent Phone _____
Parent Email _____ Home Address _____

I, _____ grant permission for my child listed above to participate in the 2024 Diocese of Crookston Youth Conference, held at the Sanford Center in Bemidji, MN. This activity MAY require transportation to and from the parish site and will take place under the direction of diocesan employees and parish employees and/or volunteers in the Diocese of Crookston. A brief description follows:

TYPE OF EVENT - Diocesan Youth Conference
LOCATION OF EVENT - The Sanford Center, Bemidji, MN
DATE OF EVENT - September 29, 2024
PERSONS IN CHARGE - Robert Noel, Misty Mehrkens, Cassandra Johnson

Liability Waiver

PARENT/GUARDIAN, ON BEHALF OF THE CHILD, HEREBY ASSUMES ALL OF THE RISKS OF PARTICIPATING IN ANY/ALL ACTIVITIES ASSOCIATED WITH THIS EVENT, including by way of example and not limitation, any risks that may arise from negligence or carelessness on part of the persons or entities being released from dangerous or property owned, maintained, or controlled by them, or because of their possible liability without fault.

Parent/Guardian acknowledges that this Accident Waiver and Release of Liability Form will be used by Diocese of Crookston, its officers, directors and agents, chaperones, or representatives associated with the activity, and that it will govern my actions and responsibilities at said activity.

Parent/Guardian, on behalf of the child, heirs, executor, and assigns, I hereby:

- (A) WAIVE, RELEASE, AND DISCHARGE from any and all liability, including but not limited to, liability arising from the negligence or fault of the entities or persons released, for my death, disability, personal injury, property damage, property theft, or actions of any kind which may hereafter occur to me, including my traveling to and from this activity, THE FOLLOWING ENTITIES OR PERSONS: The Diocese of Crookston, their directors, officers, employees, volunteers, representatives, and agents, and the activity holders, sponsors, and volunteers;
- (B) INDEMNIFY, HOLD HARMLESS, AND PROMISE NOT TO SUE the aforementioned entities or persons from any and all liabilities or claims made as a result of participation in this activity, whether caused by the negligence of release or otherwise.

Parent/Guardian acknowledges that The Diocese of Crookston and their directors, officers, volunteers, representatives, and agents are NOT responsible for the errors, omissions, acts, or failures to act of any party or entity conducting a specific activity on their behalf.

Parent/Guardian understands that while participating in this activity, my child may be photographed. I agree to allow my photo, video, or film likeness to be used for any legitimate purpose by the activity holders, producers, sponsors, organizers, and assigns.

This waiver shall be construed broadly to provide a release and waiver to the maximum extent permissible under applicable law.

I CERTIFY THAT I HAVE READ THIS DOCUMENT AND I FULLY UNDERSTAND ITS CONTENT. I AM AWARE THAT THIS IS A RELEASE OF LIABILITY AND CONTRACT AND I SIGN IT OF MY OWN FREE WILL. BY SIGNING MY NAME BELOW, I AGREE TO THE ABOVE TERMS AND CONDITIONS.

Parent/Guardian Signature: _____ Date: _____

Diocese of Crookston - DCYC MEDICAL MATTERS FORM

I hereby warrant that to the best of my knowledge; my child is in good health.

Parent Signature → _____

The Diocese of Crookston will take reasonable care to see that the following information will be used only for its intended purpose and shall not be released to a third party unless necessary for medical treatment of the child.

Youth Participant's Last Name _____ First Name _____

A. 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 treatment by the hospital or doctor. In the event of an emergency where I am unable to make a decision please contact:

Name & Relationship: _____ Phone: _____

Family doctor: _____ Phone: _____

Family Health Plan Carrier: _____ Policy # _____ Group # _____

B. Medications – Please Read Carefully

____ **Initial Here if:** My child is taking medications at present time: My child will bring all such medications necessary, and such medications will be well labeled. Names of medications and concise directions, including dosage and frequency of dosage, are as follows: _____

Please read carefully before initialing.

____ **Initial Here if NO MEDICATION** of any type, whether prescription or non, may be administered to my child unless the situation is life threatening and emergency treatment is required.

Please read carefully before initialing.

____ **Initial Here if:** I hereby **GRANT PERMISSION** for non-prescription medication to be given to my child, if deemed necessary.

C. Special Medical Information:

Allergic reactions (medications, foods, plants, insects, etc.) _____

*Does child have a medically prescribed diet? _____

Does child have any physical limitations? _____

You should be aware of these special medical conditions of my child: _____
