Archdiocese of San Francisco
St. Anselm Church
Youth Ministry
Parental Permission & Health Authorization Form

Please note: One completed form per youth is required and additional forms may be downloaded from our website. PLEASE COMPLETE BOTH SIDES.

Youth's Name ______________________________________ Birth Date: __________________
First Last

Cell # _________________________ Email: ____

Address ____

School _____________________________________ Grade ____________________________

Parents/Guardians Cell #s: __________________________, _____________________________

Parents/Guardians Names _________________________ ______________________________
First Last First Last

Email Addresses:

______________________________ ________________________________

Person(s) to notify in emergency (other than parent/ guardian):

Name _____________________________________ Phone ___________________________

I/We, the parent, guardians of the above named youth hereby give my/our permission to his her/participation in any and all Youth Ministry activities. I/We agree to direct my/our youth to cooperate and conform to directions & instructions of Youth Ministry personnel responsible for Youth Ministry activities.

I/We agree that in the event my/our youth is injured as a result of his/her participation in Youth Ministry activities, including transportation to & from these activities, whether or not caused by the negligence of the parish Youth Ministry program or any of its agents or employees, recourse for the payment of any resulting hospital, medical or related costs & expenses will first be had against any accident, hospital or medical insurance, or any available benefit of mine/ours.

In the event we cannot be reached in an emergency, I/we hereby give permission for:

Adult Leader(s): DRE & Youth Ministry Team
To authorize by his/her signature whatever medical treatment may be considered necessary by the attending physician for my/our youth.

Parent/Guardian Signature ___________________________________ Date _____________

Parent/Guardian Signature ___________________________________ Date _____________

Please complete reverse side…

Must be Completed by Parent/Guardian

Family Physician ______________________________ Phone ____________________

Address _____________________________________ Zip _______________________

Medical Plan _________________________________ Medical Plan # ______________

If you do not want medical care given to your youth, please state reasons:

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Does your youth have or is subject to: (check if answer is yes)

- ☐ Asthma
- ☐ Fainting spells
- ☐ Convulsions
- ☐ Diabetes
- ☐ Heart Trouble
- ☐ Allergy or reaction to ANY medication

Sport Restrictions (list) ____

Food Allergies (list) ____

Other (describe) ____

Have difficulty with: (please circle)

Eyes Ears Nose Throat Lungs Digestion Menstruation

Any condition requiring medication? ______________________________________

Name of medication? ____

Any Restriction of activity for medical reasons? Explain

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This form must be available at all Youth Ministry Activities