

ST. ANNE GODPARENT-YOUTH MINISTRY

GODPARENT GROUP _____

COST \$50.00 Payable to St. Anne's Religious Education

Personal Data

Name: _____

Address: _____

Phone: Home () _____ Cell () _____

Email: _____

Date of Birth: _____

Fathers Full Name: _____ Mothers Full Name: _____

YOUTH AUTHORIZATION

I hereby give my permission for my child _____ to participate in the Godparent Program. I hereby release and indemnify St. Anne Catholic Church, its staff, volunteers and Joliet Diocese, from any and all liability arising from claims of any kind or nature whatsoever from my child's participation in this event. I understand that my child is responsible for following certain regulations while taking part in this event.

Signature of Parent/Guardian

Address, City and State

() _____
Phone Number

() _____
Emergency Number

() _____
Phone number of closest relative

MEDICAL PERMISSION FORM

I grant permission for the administration of First Aid to my child, by the people in charge of the St. Anne Religious Education Godparent Program, and to make the necessary referrals to qualified physicians or emergency personnel for treatment of illness or accidents of a more serious nature. I understand I will be promptly notified in the event of any serious illness or accident and prior to any major surgery, except when delay in such communication would endanger life. In case of a medical emergency, I understand that every effort will be made to contact the parent/guardian of the participant. In the event that I cannot be reached, I hereby give permission to the physicians selected by the adult staff to hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery, if deemed necessary for my child.

Allergic to any medications/other: ___ No ___ Yes If yes, Please explain _____

Signature of Parent/Guardian: _____ Date: _____

Address: _____ City, State, Zip _____

Telephone Number: () _____

INSURANCE INFORMATION

Policy in the name of: _____

Insurance Company _____ Policy# _____ ID# _____

Authorized Physician: _____ Phone#: () _____

Please make payment to St Anne Religious Education in the amount of \$50.00