ANNUNCIATA YOUTH ORGANIZATION (A.Y.O)
Parental / Guardian Permission Form and Medical Authorizations

DESIGNATED SUPERVISOR OF AYO
Fr. Dennis Kriz, OSM (773) 221-1040

PARENTAL / GUARDIAN PERMISSION FORM

I HEREBY GIVE PERMISSION for my son/daughter _____ to participate in the activities sponsored or attended by the Annunciata Youth Organization of Annunciata Parish in Chicago, IL ___ YES ___ NO.

I HEREBY RELEASE AND IMDEMNIFY the Annunciata Youth Organization, Annunciata Parish, the Youth Ministry Office of the Archdiocese of Chicago and their staffs, volunteers, and the Catholic Bishop of Chicago, a corporation sole, from any and all liability arising from claims of any kind or nature whatsoever from my child's (1) participation in, and (2) transportation to and from any and all activities sponsored or attended by the Annunciata youth Organization, I understand that if my child violates any laws regarding the possession of alcohol or drugs, or rules governing any of the events attended by my child, I will be called to pick up my child from the premises ___ YES ___NO.

I AUTHORIZE the Annunciata Youth Organization or the Youth Ministry Office of the Archdiocese of Chicago to use photographs / videos of my child for productions, publications, etc ___ YES ___ NO.

MEDICAL AUTHORIZATIONS

In the event that the undersigned cannot be reached, and in the judgement of the responsible adults or other appropriate staff members accompanying the group, if there is a necessity for immediate examination and/or treatment of my child, I hereby authorize any of the aforesaid personnel to obtain for my child such medical services as are deemed necessary. ___ YES ___ NO

I GRANT PERMISSION for the adult chaperones of AYO to administry non-prescription drugs as needed for my teen (asperin, ibuprofen, antacides, etc) ___ YES ___ NO

EMERGENCY CONTACT (in event parent(s) / guardian(s) can ot be reached):

Name of Emergency Contact: _____
Relationship: _____ Phone Number: (___) _____

PARENT(S) / GUARDIAN(S)

Signature _____ Signature _____
Address _____ Address _____
_____ _____
Date _____ Ph: (___) _____ Date _____ Ph: (___) _____

PHYSICIAN INFORMATION

NAME OF PHYSICIAN _____ Ph: (___) _____
Address: _____

INSURANCE INFORMATION

Policy in Name of _____ Policy # _____
Insurance Company _____ ID # _____

HEALTH INFORMATION

Allergies _____ Current Med. _____
Other Comments _____