

St. Boniface Youth Ministry



Youth Information

Name	
Street Address	
City	
Cell / Home Phone	
E-Mail Address	
Date of Birth	

Best Way to Contact (select all that apply)

- Email Phone Call
 Text Facebook

Parent/Guardian Information

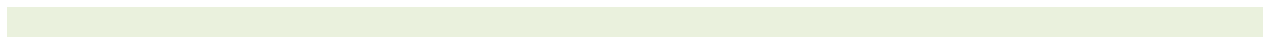
Name	
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Best Way to Contact (Select all that apply)

- Email Phone Call
 Text

I am willing to help:

- Chaperone / Drive to Events Referee
 Coach Softball Umpire
 Coach Basketball Fundraising



North Central Vicariate – Catholic Youth Ministry

Medical Information and Consent Form – January 1, 2016- December 31, 2016

Parish/City: St. Boniface

Participant's Name: _____ Date of Birth: _____

Parent(s)/Guardians Name(s): _____

Address: _____

City/State: _____

Phone # : _____ Cell #: _____

Emergency Contact (if parent/guardian cannot be reached)

Name: _____ Phone: _____

Physician's Name: _____ Phone: _____

Medical Information:

1. Does the participant take medications regularly? _____ Yes _____ No
2. Does the participant have any allergies or chronic illnesses? _____ Yes _____ No
3. Is the participant allergic to any drugs or medications? _____ Yes _____ No

List participants Medical Insurance:

Name of Insurer _____

Policy/Group # _____

In the event that my child, _____ requires emergency medical treatment due to illness or injury, I hereby give my consent to the following:

1. Parish volunteer supervising my child to arrange for emergency medical care at an appropriate medical facility;
2. Medical personnel at the medical facility to render necessary treatment to my child.

I further acknowledge and agree that I will assume responsibility for payment of all expenses associated with the medical care above described.

Parent/Guardian Signature _____ Date _____