MEDICAL RELEASE AND PARENT INFORMATION

(Please print clearly. Thank you!)

Youth Name _____

Parent Name_____

Phone_____

Email _____

Other Parent Name_____Phone_____

Address(if different from Youth)_____

Emergency Contact & Phone_____

Allergies_____

Medications_____

Family Physician & Phone_____

Medical Insurance Company _____

Policy #_____

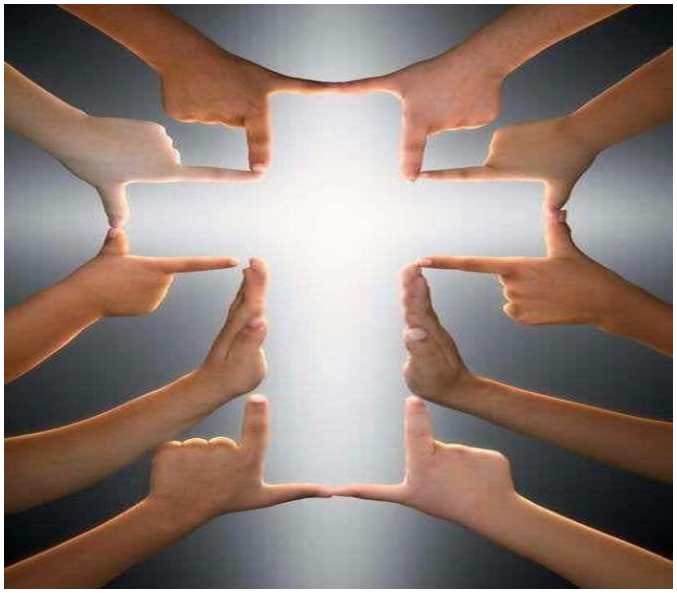
Do we have permission to administer Tylenol or Ibuprofen? _____

I, the undersigned, parent or guardian of _____ do hereby authorize the adult(s) representing the Archdiocese of Louisville Catholic Youth Ministries as my agents, to consent to any examinations, X-ray, anesthetic, medical, or surgical diagnosis or treatment and hospital care deemed advisable by a qualified physician or local hospital. A Catholic Youth Ministries representative agrees to contact the undersigned as soon as possible if any emergency should arise. I will assume responsibility for fees incurred by such an emergency. In addition, I certify that the above information is correct and give permission for the release of medical records to the attending physician. I realize that I cannot hold the parish or the Archdiocese of Louisville responsible for such and emergency.

Parent/Guardian Signature_____Date_____

ARCHDIOCESE OF LOUISVILLE CHRISTIAN AWAKENING

RETREAT 2019



FLAGET RETREAT CENTER LOUISVILLE, KY

MARCH 15-17, 2019

Catholic Services Appeal
Bringing Christ to Others
1968-2017
50th ANNIVERSARY