

# Holy Trinity High School Youth Ministry Steubenville 2012

**July 12-15, 2012**



[http://www.holytrinityparish.net/youth\\_ministry.html](http://www.holytrinityparish.net/youth_ministry.html)

**Depart:** July 12, Holy Trinity at 5:00 p.m.      **Return:** July 15, Holy Trinity by 8 pm

✂----- Save this part↑----- ✂Fill out and submit this by May 31<sup>st</sup>, 2012 ↓ ----- ✂ ---  
Steubenville Permission and Emergency Release Form

Participant's name: \_\_\_\_\_ Date of Birthday: \_\_\_\_\_

High School: \_\_\_\_\_ High School Graduation Year: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Participant's Email Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Family Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Please list any medical concerns (e.g. allergies) that your child has and that we need to be aware of:  
\_\_\_\_\_

List any medication your child will need administered on this outing: \_\_\_\_\_  
\_\_\_\_\_

Parents: if drivers are needed! I am able to drive \_\_\_\_\_ youths. *(We will call you by the Wednesday before the trip if we need you to drive.)*

I, \_\_\_\_\_, parent/guardian of \_\_\_\_\_, agree to indemnify the Holy Trinity Parish, Youth Ministers, Volunteers, and the Diocese of Arlington for any costs or expenses arising out of my child's participation in **Steubenville 2012**, including the cost of any medical care given my child or any expenses or fees incurred in any lawsuit arising as a result of any damage or injuries caused by my child in the course of his or her participation in the activity.

I further give my consent to that in my absence the above-named minor be admitted to any hospital or medical facility for diagnosis and treatment. I request and authorize physicians, dentists, and staff, duly licensed as Doctors of Medicine or Doctors of Dentistry or other such licensed technicians or nurses, to perform any diagnostic procedures, treatment procedures, operative procedures and x-ray treatment of the above minor. I have not been given a guarantee as to the results of examination or treatment. I authorize the hospital or medical facility to dispose of any specimen or tissue taken from the above-named minor. I authorize the Holy Trinity Youth Ministry to use my child's picture or video recording for educational and/or marketing purposes. Parents/guardians who do not wish their child to be photographed or filmed should so notify Holy Trinity Youth Ministry in writing.

Signature of parent or guardian: \_\_\_\_\_ Date: \_\_\_\_\_

For Office Use Only:	Date:	Check Number:	Amount:
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