



**Diocese of Kansas City – St. Joseph**  
**PARTICIPATION FORM FOR YOUTH MINISTRY EVENTS**

(Please Print)

**I. Event Information**

Parish/School/Organization Name: **Diocese of KC-SJ Respect Life Office**

Event: **2011 March for Life**

Destination: **Washington, D.C**

Date/Time of Departure: **Early morning Jan 23, 2011**

Date/Time of Return: **Early evening Jan 25, 2011**

Method of Transportation: **Bus**

Participation Cost: **\$200**

**II. Participant Information**

Name of Participant: \_\_\_\_\_

Gender: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Name of Parent/Guardian: \_\_\_\_\_

Home Telephone: \_\_\_\_\_ Mobile: \_\_\_\_\_ Work: \_\_\_\_\_

Other Contacts in case of illness or injury:

Name/Phone: \_\_\_\_\_

Name/Phone: \_\_\_\_\_

**III. Participant Health Information** (Required only for events more than 6 hours in duration)

*The following information is to be completed by a parent or legal guardian. Additional information and or comments may be attached to this form.*

Are you in general good health and able to participate in normal activities? \_\_\_\_ Yes \_\_\_\_ No

If No, describe your limitations: \_\_\_\_\_

All immunizations up to date? \_\_\_\_ Yes \_\_\_\_ No

Physician's Name/Telephone: \_\_\_\_\_

Participant's Health Insurance Provider: \_\_\_\_\_

Policy or Group# \_\_\_\_\_

Primary Policyholder's Name : \_\_\_\_\_

1.) This youth has been diagnosed or has experienced having the following condition \_\_\_\_\_

2.) Is medication required for this condition? Yes \_\_\_\_ No \_\_\_\_

If required, list names of medication and dosage.

Name of medication	Dosage	When to take
_____	_____	_____
_____	_____	_____
_____	_____	_____

**If the participant will have any medications (prescription or over-the-counter), please complete the Consent for Medication form (page 4 of this document).**

3.) Are there any restrictions for this child? Yes \_\_\_\_ No \_\_\_\_

If any, please list. \_\_\_\_\_

4.) Are there any specific treatments or special care? Yes \_\_\_\_ No \_\_\_\_

If so, please list. \_\_\_\_\_

5.) In case of medical emergency due to the child's health condition, diocesan/parish staff should do the following:

\_\_\_\_\_

6.) List known allergies (medications, food, all other allergies): \_\_\_\_\_

\_\_\_\_\_

7.) Additional Comments: \_\_\_\_\_

\_\_\_\_\_

I request that this Care Plan be used to guide care for my child. I agree to provide necessary supplies and equipment, notify the youth minister of any changes in the youth's health status, and update this Care Plan as changes are made. I understand that information in this care plan will be shared with the diocesan/parish youth staff and volunteers directly involved with my child as needed. Further, I indemnify and hold harmless this ministry, parish, the Diocese of Kansas City-St. Joseph and its employees or agents against any claims from the use of this care plan.

**IV. Permission of Parent/Guardian**

I/We, the parent(s)/guardian(s) of \_\_\_\_\_, request that he/she be allowed to participate in the Event described above, and hereby give my/our permission for such participation.

I/We give my/our permission to the sponsoring Diocese/Parish/School/Organization to take photographs, video or digital images of Participant during the Event for future promotional purposes.

**V. Consent for Disclosure to Individual Involved in the Care and Treatment of Participant**

For the duration of the Event, I/We grant to the Diocese/Parish/School/Organization and its agents the following powers, to be used for the benefit of and on behalf of Participant:

to receive any and all individually identifiable health information about the past, present and future medical condition of Participant, including, but not limited to, information necessary to the care and treatment of Participant and any illness or injury Participant may have sustained;

to authorize medical care for Participant, including, but not limited to, any and all treatment, examination, diagnosis or outpatient medical care rendered under the general or special supervision of and on the advice of any physician or surgeon licensed to practice medicine by the applicable licensing body in the state in which physician or surgeon practices.

I/We understand that the Diocese/Parish/School/Organization will not be liable to me/us or any or my/our successors in interest for any action taken or not taken in good faith.

I/We consent to the logistics and conditions described above, including the method of transportation.

I/We understand that as parent(s) or legal guardian(s) I/we may be responsible for any liability which may result from the conduct of Participant at or during the Event.

I/We understand that there is a risk of injury involved in any Youth Ministry activity. I/We hereby release the Diocese of Kansas City-St. Joseph, and its officers, agents, employees and volunteers, from any liability arising from claims of any kind or nature whatsoever in connection with Participant's participation in the Event.

\_\_\_\_\_  
**Signature of Parent/Guardian**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Signature of Parent/Guardian**

\_\_\_\_\_  
**Date**

*Forms will be kept on file in the Respect Life Office for a period of one year following the Event.*

**Questions:** Contact the Respect Life Office at 816-756-1850 or [nordhus@diocesekcsj.org](mailto:nordhus@diocesekcsj.org)

**Return completed forms to:** Diocese of Kansas City-St. Joseph, Respect Life Office  
P.O. Box 419037, Kansas City, MO 64141-6037

Fiscal Year: **July 1, 2010- June 30, 2011**  
(Consent expires at the end of this fiscal year)

If the participant will have any medications (prescription or over-the-counter), please complete this form.

**Diocese of Kansas City - St. Joseph**  
**Consent for Medication**

(Use for participation in any ministry for youth)

**HEALTH CARE PROVIDER CONSENT:**

As diocesan/parish personnel, we must have a health care provider's order before we are permitted to give any medications. This permission must be in written form and on file with the diocesan/parish youth ministry office. A new, signed form is required each fiscal year.

Youth's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Diagnosis/Reason for Medication(s) (prescription and over-the counter): \_\_\_\_\_  
\_\_\_\_\_

The Above Named Student may receive:

◇ Prescription medication according to label instructions (Prescription label serves in lieu of physician's order)

◇ Non-prescription medication as directed:

- > Acetaminophen \_\_\_\_\_
- > Ibuprofen \_\_\_\_\_
- > Cough Drops/throat lozenges \_\_\_\_\_
- > Anti-itch lotion \_\_\_\_\_
- > Allergy medication \_\_\_\_\_
- > Other \_\_\_\_\_

SPECIAL INSTRUCTIONS/COMMENTS: \_\_\_\_\_  
\_\_\_\_\_

I request and authorize that the above named youth be administered the above medications as directed while participating in youth ministry activities.

\_\_\_\_\_  
**Health Care Provider's Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
Telephone

\_\_\_\_\_  
Fax

**PLEASE NOTE: MEDICATION CANNOT BE DISPENSED FROM UNLABELED CONTAINERS. ALL PRESCRIBED MEDICATION MUST BE SENT IN A LABELED PRESCRIPTION CONTAINER FROM THE PHARMACY. ALL OVER-THE-COUNTER MEDICATION MUST BE PROVIDED IN THE ORIGINAL MANUFACTURED CONTAINER AND LABELED WITH THE YOUTH'S NAME AND DOSAGE.**

**YOUTH ARE NOT ALLOWED TO CARRY MEDICATIONS (PRESCRIPTIVE OR OVER-THE-COUNTER) WITH THEM. ALL MEDICATIONS ARE TO BE KEPT WITH DIOCESAN/PARISH STAFF MEMBERS. YOUTH WITH PROPER AUTHORIZATION MAY BE ALLOWED TO CARRY AND SELF-ADMINISTER ASTHMA OR OTHER MEDICATIONS FOR LIFE THREATENING CONDITIONS. (Contact the Diocesan/Parish Youth Ministry Staff for more information).**

**PARENT/GUARDIAN PERMISSION:** I hereby give my permission for designated youth ministry personnel to administer the medication described above as directed by the licensed health care provider. I accept responsibility for immediately notifying the youth minister of any change in these instructions. Further, I indemnify and hold harmless this ministry, parish, the Kansas City-St. Joseph Diocese and its employees or agents against any claims from the use of this/these medications.

\_\_\_\_\_  
PARENT/GUARDIAN SIGNATURE

\_\_\_\_\_  
DATE

## **Diocese of Kansas City - St. Joseph**

### **Medication Policy**

While the diocese/parish/school/early childhood center is not obliged to supply, dispense or administer medication to children/youth, in certain circumstances, medication or treatment is necessary for children/youth to be able to remain in the school/center or participate in diocesan/parish/school/center sponsored activities.

The child/youth's physician needs to send a written order for any prescription medication. This order must include the name of the drug, the dose, the time of the dose, the length of the time the medication is to be given, instructions for administration, possible adverse effects and emergency instructions. The prescription label may serve as the physician's authorization. Accompany this prescription medication with a *Consent for Medication* form signed by the parent/legal guardian.

The ministry/school/center will not dispense over-the-counter medications such as Tylenol, cough medicine, cough drops or other non-prescription medications without specific written authorization from both the child/youth's physician and parent/legal guardian. All non-prescription medication shall be in the original container and labeled by the parent/guardian with the child/youth's name and instructions for administration including times and amounts for dosages. Accompany the over-the-counter medication with a *Consent for Medication* form signed by the physician and parent/legal guardian.

With the appropriate forms on file for the current year, you may send the medications to the school/center or sponsored activities when the need arises.

Children/youth are not allowed to carry medications (prescriptive or over-the-counter) with them. All medications are to be kept with trained staff members. Children/youth may be allowed to carry and self-administer asthma or other medication for life threatening conditions with proper authorization through the health care provider and diocesan/parish/school/center staff.

Should you have any questions regarding this medication policy, please contact the school/center/ministry. We work very hard to ensure the safety of your child/youth as well as all those in our care.