

**Archdiocese of San Francisco  
St. Anselm  
Religious Education Program  
Parental Permission & Health Authorization Form**

Child's/Youth's Name(s)

Birth Date:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Persons to notify in emergency (other than parent):

Name: \_\_\_\_\_

Phone: \_\_\_\_\_

I/We, the parent, guardians of the above named child hereby give my/our permission to his her/participation in any and all Religious Education activities. I/We agree to direct my/our child to cooperate and conform with directions & instructions of Religious Ed personnel responsible for Religious Education activities.

I/We agree that in the event my/our child is injured as a result of his/her participation in Religious Education activities, including transportation to & from these activities, whether or not caused by the negligence of the parish/school Religious Education program or any of its agents or employees, recourse for the payment of any resulting hospital, medical or related costs & expenses will first be had against any accident, hospital or medical insurance, or any available benefit of mine/ours.

In the event we cannot be reached in an emergency, I/we hereby give permission for Adult Leader: Tom Kavanagh to authorize by his signature whatever medical treatment may be considered necessary by the attending physician for my/our child(ren).

Parent/ Guardian Name

\_\_\_\_\_

Phone Numbers:

Cell: \_\_\_\_\_

Home: \_\_\_\_\_

Business: \_\_\_\_\_

Date: \_\_\_\_\_

Signature:

\_\_\_\_\_

Parent/ Guardian Name

\_\_\_\_\_

Phone Numbers:

Cell: \_\_\_\_\_

Home: \_\_\_\_\_

Business: \_\_\_\_\_

Date: \_\_\_\_\_

Signature:

\_\_\_\_\_

**Note: One Form Per Child**  
**Must be Completed by Parent/Guardian**

**Child's Name:** \_\_\_\_\_

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

Address \_\_\_\_\_ Zip \_\_\_\_\_

Medical Plan \_\_\_\_\_ Medical Plan Number \_\_\_\_\_

If you do not want medical care given to your child, please state reasons:

\_\_\_\_\_  
\_\_\_\_\_

Does your child have or is subject to: (check if answer is yes)

Asthma                      Fainting spells                      Convulsions                      Diabetes

Heart Trouble                      Allergy or reaction to ANY medication

Sport Restrictions (list) \_\_\_\_\_

Other (describe) \_\_\_\_\_

Have difficulty with: (please circle)

Eyes      Ears      Nose      Throat      Lungs      Digestion      Menstruation

Any condition requiring medication? \_\_\_\_\_

Name of medication? \_\_\_\_\_

Any Restriction of activity for medical reasons? Explain

\_\_\_\_\_  
\_\_\_\_\_

**This form must be available at all Religious Education Program Activities**