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***Catholic Mutual. . . “CARES” ATHLETIC AND SPORTING EVENTS***  
**PARENTAL/GUARDIAN CONSENT FORM AND LIABILITY WAIVER**

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Participant’s Name: \_\_\_\_\_ Male Female

Birth date:

Parent/Guardian’s Name:

Home Address:

Parent or guardian’s name & best phone #:

This activity will take place under the guidance and direction of school employees and/or volunteers from Saint Timothy Parish A brief description of the activity follows:

Type of event: Saint Timothy Summer Camp Location(s): St. John Paul II Youth Center/MTC/St. Timothy Catholic Church 17512 Lakeshore Road Lutz, FL 33558 Individuals in charge: Justin Lantz, Jen Linder, Christelle Howard Duration of activity: 9 a.m.-3 p.m. Summer May-August, 2026

As parent and/or legal guardian, I remain legally responsible for any personal actions taken by the above-named minor (“participant”).

I agree on behalf of myself, my child named herein, or our heirs, successors, and assigns, to hold harmless and defend Saint Timothy Catholic Church Parish, its officers, directors and agents, and the Diocese of St. Petersburg, coaches, chaperons, or representatives associated with the event, arising from or in connection with my child attending the event or in connection with any illness or injury or cost of medical treatment in connection therewith, and I agree to compensate the school, its officers, directors and agents, and the Diocese of St Petersburg, coaches, chaperons, or representatives associated with the activity for reasonable attorney’s fees and expenses arising in connection therewith.

Signature:

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

**MEDICAL MATTERS:** I hereby warrant that to the best of my knowledge, my child is in good health, and I assume all responsibility for the health of my child. (Of the following statements pertaining to medical matters, sign only those that are applicable.)

***Emergency Medical Treatment:*** In the event of an emergency, I hereby give permission to transport my child to a hospital for emergency medical or surgical treatment. I wish to be advised prior to any further treatment by the hospital or doctor. In the event of an emergency, if you are unable to reach me at the above numbers, contact:

Signature:

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

Emergency Contact Name & relationship:

Family doctor:

Family Health Plan Carrier:

Policy #:

**Other Medical Treatment:** In the event it comes to the attention of the school, its officers, directors and agents, and the Diocese of St Petersburg, coaches, chaperons, or representatives associated with the activity that my child becomes ill with symptoms such as headache, vomiting, sore throat, fever, diarrhea, I want to be called.

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

**Medications:** My child is taking medication at present. My child will bring all such medications necessary, and such medications will be well-labeled. Names of medications and concise directions for seeing that the child takes such medications, including dosage and frequency of dosage, are as follows:

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

No medication of any type, whether prescription or non-prescription, may be administered to my child unless the situation is life-threatening and emergency treatment is required.

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

I hereby grant permission for non-prescription medication (such as non-aspirin products, i.e. acetaminophen or ibuprofen, throat lozenges, cough syrup) to be given to my child, if deemed appropriate.

Signature: \_\_\_\_\_

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

**Specific Medical Information:** The church/school will take reasonable care to see that the following information will be held in confidence.

Allergic reactions (medications, foods, plants, insects, etc.): \_\_\_\_\_

Immunizations: \_\_\_\_\_

Date of last tetanus/diphtheria immunization: \_\_\_\_\_

Does child have a medically prescribed diet? \_\_\_\_\_

Any physical limitations? \_\_\_\_\_

Has child recently been exposed to contagious disease or conditions, such as mumps, measles, chickenpox, etc.? If so, date and disease or condition:

You should be aware of these special medical conditions of my child:

\_\_\_\_\_  
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