

**Archdiocese of Indianapolis**  
*Bishop Bruté Days*

June 14 – 17, 2011 at the Indiana FFA Center in Trafalgar

**Consent and Health Information Form**  
*(To be completed by parent or guardian)*

PARTICIPANT NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

**Please list any allergies or medical conditions:**

**If your child requires medications, please send them with your child and list these medications, including the product name and physician's instructions on dosage and frequency. Any medications brought to the retreat should be in their original container and clearly labeled:**

- 1.
- 2.
- 3.
- 4.

**Participation Consent:**

I grant permission for my child to participate in Bishop Bruté Days. I will not hold the Archdiocese of Indianapolis or the Indiana FFA Center responsible in the event of any injury or accident to my son while participating in Bishop Bruté Days. I certify that, to the best of my knowledge, my child is in good health and able to participate in all program activities (Please indicate any limitations and/or conditions of which we should be aware).

I understand that all **prescription medication will remain in the possession of the adult team leader** and be dispensed as prescribed. I grant permission for non-prescription medication (such as Tylenol, throat lozenges, cough syrup) to be given to my child if deemed advisable.

**In case of medical emergency**, I understand that every effort will be made to contact parents or guardian of participants. In the event that I cannot be reached, I hereby give permission to the Bishop Bruté Days Director to seek treatment for my son. I hereby give permission to the medical staff to hospitalize, secure proper treatment for, and to order injection, anesthesia, or surgery for my child.

*Parent/Guardian Signature:* \_\_\_\_\_

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

**Insurance Information:**

Family Health Insurance Company \_\_\_\_\_

Policy Number: \_\_\_\_\_ Name of Physician: \_\_\_\_\_

***Please complete the back of this form with important contact information.***

PARTICIPANT NAME: \_\_\_\_\_

**Emergency Contact Numbers:**

Parent or Guardian Name : \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Parent or Guardian Name : \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Other Emergency Contact Name: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

**This form should be sent in along with your registration form by June 1, 2010.**