



OFFICE OF RELIGIOUS EDUCATION AT SAINT LOUIS PARISH

PARENTAL CONSENT FOR EMERGENCY MEDICATIONS FORM

STUDENT NAME \_\_\_\_\_ SESSION \_\_\_\_\_ ROOM \_\_\_\_\_

PARENT 1: Father Mother Guardian: \_\_\_\_\_

Last Name, First Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phones:

Home \_\_\_\_\_ Work \_\_\_\_\_

Cell \_\_\_\_\_ Other \_\_\_\_\_

PARENT 2: Father Mother Guardian: \_\_\_\_\_

Last Name, First Name \_\_\_\_\_

Address (if different) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phones:

Home \_\_\_\_\_ Work \_\_\_\_\_

Cell \_\_\_\_\_ Other \_\_\_\_\_

Child(ren) in custody of: Mother & Father Mother Only Father Only Joint Custody Legal Guardian Other: \_\_\_\_\_

EMERGENCY MEDICATION ADMINISTRATION POLICY

Diocesan Policy requires that students enrolled in Religious Education [RE] Program classes or events must carry their own epi-pen(s), inhaler(s) or other medications and must be trained and able to self-administer these medications. If they cannot self-administer, then the parent/guardian must remain present on site during the entire time that the child is participating in RE events or must designate an administrator who will remain present on site during the entire time that the child is present. The child may not be left in the care of Parish staff or volunteers unless the Parent or Designated Administrator is present.

I UNDERSTAND AND CONSENT TO THIS POLICY: PARENT NAME: \_\_\_\_\_ (Please print).

I HAVE ALSO READ AND SIGNED THE WAIVER ON THE BACK OF THIS FORM. PARENT SIGNATURE: \_\_\_\_\_ (Please sign).

DESIGNATED ADMINISTRATOR OF EMERGENCY MEDICATIONS

Father Mother Other (If other, please complete the rest of this box.)

Designated Administrator Name \_\_\_\_\_ Relationship \_\_\_\_\_

Phones:

Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_ Other \_\_\_\_\_

EMERGENCY MEDICATION BACKGROUND INFORMATION

In the event of an incident requiring emergency medication, 911 will be contacted immediately. This information is requested to order to assist emergency personnel in assessing and treating the child needing medication.

Nature of Medical Condition(s) \_\_\_\_\_

Allergic/Environmental Triggers \_\_\_\_\_

Allergy usually triggered by:  Ingestion  Skin Contact  Inhalation  Insect Bite/Sting  Other: \_\_\_\_\_

Symptoms Manifest as \_\_\_\_\_

List Emergency Medication(s) Carried by Child/Parent/Designated Administrator:

1. \_\_\_\_\_ 2. \_\_\_\_\_

3. \_\_\_\_\_ 4. \_\_\_\_\_

Prescribed Use of Medications for Emergency Treatment: \_\_\_\_\_

Name of Doctor Prescribing Medication(s)/Treatment: \_\_\_\_\_ Phone: \_\_\_\_\_

DIOCESE OF ARLINGTON  
**Medical Waiver Agreement**

I, \_\_\_\_\_, am the custodial parent and/or legal guardian of \_\_\_\_\_, (hereinafter "my child"), a minor. I have requested that my child be enrolled in and participate in religious education classes and/or other activities offered by Saint Louis Catholic Church in Alexandria, Virginia.

My child has (circle any that apply) an allergic condition, asthma, or other medical condition (please specify):

\_\_\_\_\_ which may result in severe, life-threatening respiratory, cardiac, or other medical distress. I acknowledge that Saint Louis Catholic Church is not reasonably able to eliminate possible causes of such reactions from the environment in which religious education classes and other activities are conducted. I further acknowledge that the staff and volunteers of Saint Louis Catholic Church are not able to administer medication to my child in the event of such a reaction.

I have been offered the opportunity to attend the classes with my child in order to administer medication if necessary, or to provide another qualified adult of my choosing to attend the classes with my child in order to administer medication if necessary.

Therefore, in consideration of Saint Louis Catholic Church agreeing to permit my child to participate in religious education classes and/or other activities, I hereby agree and acknowledge that the Bishop of Arlington, Diocese of Arlington, Saint Louis Catholic Church, and their respective agents, employees, and volunteers will not be held responsible or liable for any injury, death or other costs, damages or liabilities of any nature suffered by or in relation to my child as a result of the above-named medical condition, or because of failure to administer medication for such condition, or for any act or failure to act in relation to any distress suffered by my child in relation to such condition. I hereby release the Bishop of Arlington, Diocese of Arlington, Saint Louis Catholic Church, their respective agents, employees, and volunteers, and any of their successors and assignees, from any and all claims, demands or suits for costs, damages, liabilities, injuries or death which my child or I may incur during religious education classes or other activities, and I assume all risks for such injuries, death, costs, damages, or liabilities.

I understand this document shall be construed and interpreted according to the laws of the Commonwealth of Virginia, and venue for any proceedings to interpret or enforce its provisions shall be in Arlington, Virginia. I have read this Medical Waiver Agreement in its entirety and understand the terms of this document, which shall also be binding upon my heirs, administrators, executors, successors and assigns.

Name of Student: \_\_\_\_\_ Birth Date: \_\_\_\_\_