



Catholic Diocese of Lexington

Youth Registration Form

Parent/legal guardian completes form and is responsible for the information being current. Original form is kept on file at parish/school; a copy must be readily available for all overnight or off-site events.

Youth Participant's Name _____ Prefers to be called: _____

Male ____ Female ____ Birth date _____ School & Grade: _____

Phone _____

Address _____

Parent/Guardian #1

Name _____

Home Address (street, city, zip) If different from youth

Home Phone _____ Work/Cell Phone _____

Email _____

Preferred Means of Communications: Phone ____ Email ____ Text ____

Parent/Guardian #2

Name _____

Home Address (street, city, zip) if different from youth

Home Phone _____ Work/Cell Phone _____

Email _____

Preferred Means of Communications: Phone ____ Email ____ Text ____

Is anyone designated as the primary or sole custodial parent by court order or decree?

Please name anyone who is restrained from picking up the child



Catholic Diocese of Lexington

Emergency Medical Release

A parent/legal guardian must complete the following form at least once per year, or as needed, and is responsible for the information being current. The original of this form is to be kept on file at the parish/school; a copy must be made readily available for all overnight or off-site events

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:

Name & relationship _____

Phone: _____ Alt Phone: _____

Family doctor: _____ Phone: _____

Family Health Plan Carrier: _____ Policy: _____

Signature: _____ Date: _____

OTHER MEDICAL TREATMENT: In the event it comes to the attention of the parish/school, its officers, directors and agents, and the Diocese of Lexington, chaperones, 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 as soon as it is reasonably possible.

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 (i.e. non-aspirin products such as acetaminophen or ibuprofen, throat lozenges, cough syrup) to be given to my child, if deemed appropriate.

Signature: _____ Date: _____

SPECIFIC MEDICAL INFORMATION: The parish/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? _____

Does child have any physical limitations? _____

Is child subject to chronic homesickness, emotional reactions to new situations, sleepwalking, bedwetting, fainting? _____

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

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

Signature: _____ Date: _____