

Archdiocese of Washington  
High School Dodgeball Tournament 2019

**RELEASE AND CONSENT FORM (Minors 18 and under)**

I, \_\_\_\_\_ the undersigned, give permission for my son/daughter \_\_\_\_\_ to attend the High School Dodgeball Tournament on March 24, 2019 at St. Patrick Catholic Church/School in Rockville, MD. It is understood that reasonable caution will be taken by those persons in charge to prevent injuries. In consideration of my child's being permitted to participate in the High School Dodgeball Tournament, I personally and on behalf of my child, hereby release The Archdiocese of Washington; Donald Wuerl, Roman Catholic Archbishop of Washington; a Corporation Sole: the Catholic Youth Organization of Washington, DC and Metropolitan Area, Inc; the Office of Youth Ministry; their employees; volunteers, the coordinators and chaperones of \_\_\_\_\_ parish/organization; from any liability for injuries or damages arising or resulting from participation in the dodgeball tournament, in and/or transportation to and there from. In the event that I cannot be reached, I hereby grant permission for my son/daughter to be evaluated, diagnosed, treated and/or medicated in accordance with standard medical practice by licensed medical personnel. Permission is hereby granted to the Archdiocese of Washington to use the photographs and quotations of my son/daughter to assist in community awareness, educational efforts, related public relations purposed that may include brochures, posters, website and print media from the Archdiocese of Washington. My child agrees to abide by all rules and regulations as outlined in the Youth Code of Behavior. I understand that the Office of Youth Ministry and the Archdiocese of Washington will not be held liable if my child fails to cooperate with said regulations and that any infractions of the rules may result in immediate dismissal from the Dodgeball Tournament.

\_\_\_\_\_  
Parent or Legal Guardian signature Date

Contact Phone Number: \_\_\_\_\_

Alternate Phone Number: \_\_\_\_\_

**YOUTH**

**CODE OF BEHAVIOR**

**The following guidelines will ensure a fun and safe experience for all of us:**

- 1) The possession of alcohol and illegal drugs is clearly prohibited and is cause for dismissal.
- 2) The Parish/Organization is responsible for the overall actions of the participants.
- 3) All participants, adults and youth, will be held to the highest Christian standards of morality.

In the event that a behavior problem required disciplinary action, Archdiocese of Washington Adult chaperones or designee, along with the individual's chaperone, will address the situation and make the necessary decision.

As a member of the \_\_\_\_\_ parish, I understand and agree to the Youth Code of Behavior. I also understand and agree that my parents or legal guardian will be notified at the time of any infractions requiring my dismissal from the event and that I will be sent home at my own and or parent's/guardian's expense.

\_\_\_\_\_  
Youth signature

\_\_\_\_\_  
Date

**PARTICIPANT EMERGENCY INFORMATION FORM**  
(Minors 18 and under)

Please, print clearly:

Participant First Name	
Participant Middle Initial	
Participant Last Name	
Nickname/Name for Nametag	
T-Shirt size	
Participant Gender	
Parent /Guardian #1 Full Name	
Parent /Guardian #2 Full Name	
Participant Home Address Street	
Participant Home Address City, State, Zip	
Participant Home Phone Number	
Participant E-Mail Address	
Parent /Guardian E-Mail Address	
Parent/Guardian Cell Phone Number	
Parent/ Guardian #1 Work Phone	
Parent /Guardian #2 Work Phone	
In case of Emergency, contact (Other than parent)	
Emergency Contact Phone	

MEDICAL INFORMATION (Please Print)

My son/daughter is allergic to (medication/ food/ other):

\_\_\_\_\_

\_\_\_\_\_

My son/daughter must take the following medications and will be bringing enough medication for\_\_\_\_\_. (Indicate medication, dosage, frequency, etc. Medication must be given to your parish adult chaperone to hold/administer):

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You should be aware of these special medical conditions of needs of my child:  
(Dietary, medical, mental health, walking assistance, bee sting allergies, other conditions)

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In the event that it comes to the attention of the ADW staff, its officers and agents or representatives associated with the activity that my child becomes ill with symptoms such as headache, vomiting, sore throat, fever etc. I would like to be notified immediately:  Yes  No

Please check the box if you would like no medication of any type (prescription or non-prescription) may be administered to my child unless the situation is life threatening and emergency treatment is required.

**Please provide the following information about insurance:**

Insurance Name:
Policy Holder:
Policy #:
Group #:
Date of last Tetanus Booster:
In case of emergency notify:
Relationship to Youth:
Daytime Phone:
Evening Phone:

**Parent Signature:** \_\_\_\_\_

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