

CURE` OF ARS IGNITE YOUTH MINISTRIES
PERMISSION FORM | KC Youth for Truth
Friday, January 27, 2012, 6:00pm – 9:45pm | Cost is \$10

This permission form and moneys are due by Tuesday, January 24th.
Completed forms can be turned in at the Youth Office (CLC) or the Parish Office.
Contact us at ignite@cureyouthministry.com

Participant's Name _____

Phone number where you can be reached during activity: _____

Chaperones are needed for this event. Are you able to help? Yes / No # of Seatbelts _____

I request that my son/daughter be allowed to participate with Cure` of Ars Youth Ministries, for the activity: **KC Youth for Truth on January 27, 2012 from 6:00-9:45pm**

The cost for participating in this event is **\$10** and includes Event & Transportation.
Checks may be made payable to Cure` of Ars Church.

We will plan to leave the Catholic Life Center (CLC) on January 27, 2012 at 6:00pm sharp.
Teens will return to Cure` of Ars and arrive at the CLC around 9:45pm.

I give permission for my aforementioned child to participate. **I understand that conference sessions will include topics such as Chastity, God's Plan for Sex, Relationships, and other topics.** For more information contact the Youth Office and/or visit www.kcyft.net. In consideration of the arrangements of this activity, I hereby release and save harmless Cure` of Ars Catholic Church, any and all employees and volunteers from any and all liability for any and all injury resulting from this activity.

Parent/Guardian Signature Signed this _____ day of _____, 2012.

AUTHORIZATION FOR MEDICAL TREATMENT

Minor Son/Daughter's Name

Birthdate

Parent/Guardian Printed Name

Home Phone

Insurance Company

Policy Number

I hereby authorize the treatment, administration of anesthesia, surgical treatment(s) for my aforementioned minor son/daughter in the event of a medical situation occurring during my absence or when the hospital or physician(s) are unable to contact me. This authorization extends to any hospital, physician(s) and nursing personnel within the physician's staff where treatment is rendered in the physician's office. I release from medical responsibility and liability the hospital, physician(s), and nursing personnel from performing medical procedures acting on the authority of this medical treatment consent form which such medical provider deems necessary for my minor child.

Parent/Guardian Signature Signed this _____ day of _____, 2012.