Date received:
___/___/___

SJEYM Registration Form

271 Winchester St. Warrenton, VA 20186 *Phone: 540-347-2922*

Youth's Name: _____
Last Name First Name Middle Name

Birth Date: ___/___/___ Sex: ___ Anticipated High School Graduation Year: _____ School Attends: _____

Mailing Address: _____ Home Phone: _____

_____ Family Email: _____

Father's Name: _____ Dad Cell/Work: #_____

Mother's Name: _____ Mom Cell/Work: #_____

Custodial Parent, if different from above: _____ Phone: _____

Emergency Contact & relationship: _____ Phone: _____

Parental Permission and Liability Release: As parent/legal guardian of the participant named above, I give my permission to participate fully in from. I agree to indemnify and hereby release the Most Reverend Michael F. Burbidge Bishop of the Catholic Diocese of Arlington and his successors in office, as well as the Catholic Diocese of Arlington and all Diocesan clergy, employees, volunteers, and participating parishes and schools from any and all liability, claims, demands for personal injury, sickness and death, as well as property damage and expenses of any nature whatsoever which may be incurred by the undersigned of the participant resulting from said participant's involvement in the above mentioned event (including transportation to and from the event). Furthermore, I on behalf of the participant hereby assume all risk of personal injury, sickness, death, damage, and expenses resulting from said participant's involvement in the above-described event.

Informed Consent to Medical Treatment: I request that in my absence the above-named minor be admitted to any hospital or medical facility for diagnosis and treatment. I request and authorize physicians, dentists, and staff, duly licensed as Doctors of Medicine or Doctors of Dentistry or other such licensed technicians or nurses, to perform any diagnostic procedures, treatment procedures, operative procedures and x-ray treatment of the above minor. I have not been given a guarantee as to the results of examination or treatment. I authorize the hospital or medical facility to dispose of any specimen or tissue taken from the above-named minor. I assume full responsibility for all costs of such treatment. Further, should it be necessary for the participate to return home due to medical, disciplinary, or other reasons, I do hereby assume responsibility for the patient's transportation home and any costs related thereto.

Required Physician and Medical Insurance Info:

Are there any medical conditions/issues which may affect the participant's involvement in the YM event?

_____

Are there any known allergies including allergies to medicine?

_____

Primary Healthcare Provider: _____

Primary Healthcare Provider Phone: _____

Insurance Company required: _____

Insurance Company Policy Number: _____

I understand and agree to the terms and conditions of the participant's involvement in the above described event and I freely execute this Acknowledgement with full knowledge of its content.

Required: Signature of Parent or Legal Guardian: _____ **Date:** _____