

**SAINT MARK CHURCH**  
**THE ARCHDIOCESE OF BALTIMORE & THE DIVISION OF YOUTH AND YOUNG ADULT MINISTRY**  
**PARENTAL AGREEMENT & PERMISSION FORM**

Name of Youth \_\_\_\_\_ Male Female (please circle)

Parent(s) Name: \_\_\_\_\_ Home Phone # \_\_\_\_\_

Work Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_

Address \_\_\_\_\_ City/Zip \_\_\_\_\_

Emergency contact Name and Phone # \_\_\_\_\_

Youth Date of Birth \_\_\_\_\_ Grade \_\_\_\_\_ Participant E-Mail Address \_\_\_\_\_

Youth Social Security # \_\_\_\_\_

In consideration of the wholesome recreational and learning experience in which my son/daughter will participate, I as parent or guardian of my son/ daughter, do hereby agree to allow my son/daughter to accompany the youth ministry group of their parish to: (event/date/time) \_\_\_\_\_

\_\_\_\_\_ (the program)

I/we acknowledge receipt of the information or information sheet describing the planned activities.

In consideration of the opportunity for my son/daughter to participate in this program, I agree to release and hold harmless and indemnify the Church of St. Mark, Fallston, (the parish of St. Mark), the Division of Youth and Young Adult Ministry, the Roman Catholic Bishop of Baltimore and his successors, a Corporate Sole, and all their agents, servants, and employees from any liability, claims, demands, and causes of action arising out of or relating to any loss, damage or injury sustained in connection with or arising out of my son/daughter's participation in the program.

I hereby grant permission to any staff person to obtain medical care from a licensed physician, hospital, or medical clinic for my son/daughter in the event that I cannot be reached. **\*\*PLEASE CHECK ONE OF THE FOLLOWING**

I am covered by hospitalization and medical insurance under policy # \_\_\_\_\_ issued by \_\_\_\_\_.

I do not have medical coverage and assume responsibility for the cost of hospitalization and medical care for my son/daughter.

Witness our hands and seals this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

\*\*\*I hereby grant permission to any staff person to provide the following over-the-counter drugs to my son/daughter if requested by my son/daughter (please circle those which apply)

Tylenol Benadryl Advil Sudafed Midol Kaopectate Neosporin Pepto Bismol

OVER →

