

**DIOCESE OF BRIDGEPORT – OFFICE OF PASTORAL SERVICES – YOUTH MINISTRY
LIABILITY/MEDICAL RELEASE FORM – YOUTH PARTICIPANT**

Name _____ Birth Date _____ Year of Graduation _____

Address _____

City _____ State _____ Zip _____ Phone _____

E-mail _____ Parish _____

PARENT / GUARDIAN: I, _____ (full name), give permission to my above-named son/daughter to participate in the **March for Life Teen Pilgrimage** to be held on **January 21st and 22nd in Washington D.C.** If needed for health reasons, I give permission for my child to be evaluated, diagnosed, treated and/or given medication in accordance with standard medical practice by licensed medical personnel. I relieve the Diocese of Bridgeport or any of its agents of all responsibility and consequences that may arise as a result of this treatment. I will not hold the Diocese of Bridgeport or any of its agents liable in the event of injury. Further, I agree to accept any and all financial responsibility as a result of scheduling medical treatment.

My child agrees to abide by all rules and regulations stated by the Diocese of Bridgeport. I understand that the Diocese of Bridgeport or any of its agents will not be held liable if my child fails to cooperate with regulations, and that any infraction of the rules may result in immediate dismissal from the event at my expense.

I give permission to the Diocese of Bridgeport to photograph, videotape and/or film my child and to use his or her image in photographs, video, and/or film for the purpose of promoting the mission, activities, and programs of the **March for Life Teen Pilgrimage**. I understand that I and my child are not entitled to any compensation or rights in these materials, and I release the Diocese of Bridgeport or any of its agents from any liability for the use of my child's image for the above stated purposes.

DATE: _____

SIGNATURE OF PARENT/LEGAL GUARDIAN

Parent/Legal Guardian Printed Name: _____

Family Physician _____ Phone # (_____) _____

Allergies or Medical Conditions (be specific) _____

Current Medications _____

Medical History (be specific) _____

Medical Insurance Provider _____ Insurance # _____

In case of emergency, please contact:

Name _____ Phone (_____) _____ Cell (_____) _____

Name _____ Phone (_____) _____ Cell (_____) _____

Please return this form and a check for \$100 to Mimi Giannino at the Catholic Center at 238 Jewett Ave, Bridgeport, CT 06606 no later than January 8th.