

**Sacred Heart Catholic Church**  
**7809 46<sup>th</sup> Way N., Pinellas Park, FL 33781**  
**(727) 541-4447**

**ANNUAL PARENTAL PERMISSION/RELEASE (August 1, 2020 thru July 31, 2021)**  
**for Communication, Photos, and Medical**

**Method of Communication Release:**

Effective ministry to youth requires that the parish Coordinator of Youth Ministry and members of the Youth Ministry Team be in contact with your teenager. We are happy to communicate in ways that you think most appropriate for your situation. For each method listed, please indicate "YES," you give permission for the Coordinator and Team to use this method or "NO," you do not give permission. When you check "YES," please provide the necessary account, number, etc. in the blank.

**Yes    No**

- Email address \_\_\_\_\_
- Facebook \_\_\_\_\_
- Instant Messaging \_\_\_\_\_
- Home phone \_\_\_\_\_
- Cell phone (voice) \_\_\_\_\_
- Text message \_\_\_\_\_
- Postal mail \_\_\_\_\_
- Online meeting platforms; e.g. zoom \_\_\_\_\_

I, as parent/guardian, would also like to receive email or text messages of all dates for meetings and/or changes in the calendar of events.     Yes     No

Email address: \_\_\_\_\_

Cell phone: \_\_\_\_\_

Prefer:     email     text

**Publicity/Photo/Video Release:**

To promote and highlight the good things happening in our Youth Ministry Program, we create social media posts, livestream and recorded videos, publicity releases for newspapers and television, website and parish bulletin articles, and similar communications intended for the parish and public. These may include photos or videos of the teens.

Yes     No    I give permission for my teen's first name and likeness to be included in such publicity/photos/videos.

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IN CASE OF AN ACCIDENT OR SERIOUS ILLNESS, THE ABOVE PARISH WILL CONTACT THE PARENT/GUARDIAN LISTED BELOW. IF THE PARISH IS UNABLE TO REACH THEM, OR ANY OTHER PERSON DESIGNATED, THEN I HEREBY AUTHORIZE THE CHURCH AND ITS REPRESENTATIVES TO CONTACT MY CHILD'S PHYSICIAN AND/OR MAKE ARRANGEMENTS FOR IMMEDIATE EMERGENCY TREATMENT. PAYMENT OR FEES FOR ALL MEDICAL SERVICES WILL BE THE RESPONSIBILITY OF THE PARENT/GUARDIAN. **THIS MEDICAL RELEASE IS VALID FROM AUGUST 1, 2020 UNTIL JULY 31, 2021** AND FOR ALL EVENTS THROUGHOUT THE YEAR. I UNDERSTAND THAT IT IS THE PARENT'S RESPONSIBILITY TO UPDATE THIS FORM AS NECESSARY THROUGHOUT THE YEAR.

Youth/Participant's Name: \_\_\_\_\_  
Parent or Legal Guardian's Name \_\_\_\_\_ Phone(s) \_\_\_\_\_  
Emergency contact information: \_\_\_\_\_  
Family Physician's Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Insurance Co. Name \_\_\_\_\_ Medical Insurance: ID number \_\_\_\_\_  
Group Number \_\_\_\_\_ Cardholder's Name \_\_\_\_\_

**Health Information**

List all medications taken daily and/or regularly: \_\_\_\_\_  
\_\_\_\_\_

Youth/participant's allergies, if any, including medication and food allergies: \_\_\_\_\_  
\_\_\_\_\_

Youth/participant's chronic medical problems (e.g. diabetes, epilepsy): \_\_\_\_\_  
\_\_\_\_\_

Youth/participant's other physical restrictions or dietary requirements (if any): \_\_\_\_\_  
\_\_\_\_\_

Date of Tetanus: \_\_\_\_\_ Other medical: \_\_\_\_\_

**My child may be given:** Tylenol  Yes  No Ibuprofen  Yes  No  
Throat lozenges  Yes  No Benadryl  Yes  No

\_\_\_\_\_  
Signature of Parent/Guardian Date

**STATE OF FLORIDA, COUNTY OF** \_\_\_\_\_

Sworn to and subscribed before me this \_\_\_\_ day of \_\_\_\_\_, 20\_\_ who  is personally known to me,  
or  who produced the following as identification \_\_\_\_\_.

(SEAL)

\_\_\_\_\_  
Signature of Notary Public

\_\_\_\_\_  
Typed or printed name

\_\_\_\_\_  
Commission No.