Mystical Rose Daughters of Faith event
REGISTRATION, PERMISSION AND MEDICAL RELEASE FORM

I hereby consent that my daughter, _____, may participate in the Diocese of Gaylord's Mystical Rose event on September 23, 2017 at St. Mary Cathedral and the Diocesan Pastoral Center in Gaylord. I understand I am responsible for arranging transportation to and from the event. As parent or legal guardian, I understand that I remain fully responsible for the actions and conduct of my daughter in accordance with Diocesan guidelines and policies.

I further give permission for any photos taken of my daughter during the event, along with her name, parish and city, to be used in future publicity (i.e. print, broadcast, website) efforts of the Diocese of Gaylord.

I hereby agree on behalf of myself and my daughter to release the Diocese of Gaylord and any and all affiliated organizations, their employees, agents and representatives, including volunteer drivers (collectively "releasees") from any and all claims, including negligence, which may be asserted by me or my daughter, or on behalf of my daughter, arising from or relating to my daughter's participation in the event. In the event this release is held to be invalid or unenforceable, I hereby agree to indemnify and hold harmless Releasees from any and all claims, including negligence, which may be asserted by me or my daughter, or on behalf of my daughter, arising from or relating to my daughter's participation in the event. This release or indemnification does not apply to claims for intentional misconduct or gross negligence, nor does this release or indemnification apply to the extent of commercial insurance coverage for any claim, but this release or indemnification shall apply to the extent of any self-insurance or deductible applicable to any claim.

As a parent/guardian of the student named below, I do hereby authorize the medical treatment by a qualified and licensed medical doctor in an emergency which, in the opinion of the attending physician, may endanger his/her life, cause disfigurement, physical impairment, or undue discomfort if delayed. This authority is granted only after a reasonable effort has been made to reach me. I further authorize the person who presents the minor to sign the Acknowledgement of Receipt of Notice of Privacy Rights that may be presented by the physician or health care facility. This medical authorization is completed of my own free will with the sole purpose of authorizing medical treatment deemed necessary/appropriate by the treating physician.

PLEASE COMPLETE THE FOLLOWING INFORMATION. PLEASE PRINT LEGIBLY:

Name: _____ Birthdate: _____ Age: _____ Entering Grade this Fall: ___

Address: _____ City: _____ Zip: _____

Phone: _____ E-mail: _____Eucharistic Minister/Lector/Music:_____

Parent/Guardian Name: _____ Emergency Phone: _____

Home Parish: _____ City _____

Family Physician: _____ Phone: _____

Physician's address: _____ City: _____ Zip:_____

Allergies: _____ Medications: _____

Please list any special dietary or other needs: _____

Health Insurance Company: _____ Policy #: _____

Group: _____Contract: _____

Parent/Guardian Signature: _____ **Date:** _____

Please RSVP to mhahnenberg@dioceseofgaylord.org
Please bring this form with you and $15 on September 23, 2017 or mail to the address:
Marie Hahnenberg, Diocese of Gaylord, 611 West North Street, Gaylord, MI 49735