

TWO-SIDE FORM

**ST. ISIDORE CHURCH
FAITH FORMATION OFFICE**

440 La Gonda Way • Suite 210 • Danville, CA • (925) 362-1900 • (925) 362-1929 (fax)

DIOCESE OF OAKLAND PARENTAL PERMISSION AND HEALTH AUTHORIZATION FORM

Child's Name: _____ Home Phone #: _____

Home Address: _____ City: _____ Zip: _____

Child's School: _____ Grade: _____ Birth date: _____

Parent/Guardian's Name: _____

Cell #: _____ Work #: _____

Person(s) other than the Parent/Guardian to notify in case of emergency:

Contact's Name: _____ Home #: _____

Work #: _____ Cell #: _____

I/We, the parent(s)/authorized guardian(s) of the child named above give permission for his/her participation in any Faith Formation activities. I/We agree to direct my/our child to cooperate and comply with reasonable directions and instructions of Faith Formation staff and volunteer catechists.

I/We agree that in the event that my/our child is injured as a result of his/her participation in Faith Formation activities, including transportation to and from these activities, whether or not caused by the negligence of the parish, Faith Formation program, or any of its agents, employees or volunteers, recourse for payment of any resulting hospital, medical or related costs and expenses will first be had against any accidents, hospital or medical insurance, or any available benefit of mine/ours.

In the event we cannot be reached in an emergency, I/we hereby give permission for the catechist or director to authorize by his/her signature whatever medical treatment may be considered necessary by the attending physician for my/our child.

If you do not want medical care given to your child, please state reason: _____

Child has difficulty with or is subject to (check if applicable):

Asthma	Food/dairy allergy	Peanut/nut allergy	Diabetes	Heart Trouble
Eyes	Ears	Nose	Throat	Lung
Digestion	Menstrual	Fainting Spells	Convulsion	Other: _____

Any condition currently requiring medication? Name of medication: _____
Allergy or reaction to **ANY** medication? Name of medication: _____
Any restriction of activity for medical reasons? Explain: _____

Physicians Name: _____ Phone #: _____

Physician's Address: _____ City: _____ Zip: _____

Medical Plan: _____ Plan #: _____

Mother/Father Signature: _____ Date: _____

Guardian Signature: _____ Date: _____

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DISASTER DISMISSAL FORM

Child's Name: _____ Grade: _____
Home Address: _____ City: _____ Zip: _____
Home Phone #: _____
Mother's Name: _____ Phone #: _____ cell/work
Father's Name: _____ Phone #: _____ cell/work

Please list below the names of all those to whom you give permission for authorized St. Isidore Faith Formation personnel to dismiss your child to in the event of a disaster. List at least three people who would not have difficulty getting to St. Isidore if you are not able to.

1. Do not list parents.
2. Do not list St. Isidore Faith Formation Staff as they cannot be responsible for individual students.
3. Please inform those people listed below that you have not done so. They should be aware that they are to come to school to pick up in the event of a disaster (earthquake, etc.) They will not receive a phone call. Please inform them of the correct procedure for dismissal.
4. Turn your radio dial to KKIQ, 101.7 FM (the local station based in Pleasanton) for school access routes. (Most stations broadcast some information, such as: KNBR 680 AM; KUIK 95.3 FM, Vacaville: Alice 97.3 SF, etc.)

Emergency Contacts:

	Name	Phone Number	Relationship to student
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

Parent Signature: _____ Date: _____
Guardian's Signature: _____ Date: _____

*** Office Use Only ***

Child released to: _____ Date: _____ Time: _____
Location: _____ Notes: _____