



PARENT PERMISSION AND RELEASE OF LIABILITY

Child Name: _____ Date of Birth: _____

Social Security #: _____ Grade/Age: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Email address: _____

Other Emergency Contact: _____ Phone: _____

Family Doctor: _____ Phone: _____

Insurance Co.: _____ If None Please Check:

Insurance Policy Name and #: _____

Known Medical Conditions: _____

List Medications _____

Any known Allergies _____

Last Tetanus Immunization? _____

Will You Allow Blood Transfusions? (check your response) Yes No

Other Comments: _____

This authorization shall remain effective until terminated in writing.

Parental Consent:

(I) (We), the undersigned, parent(s) of _____, a minor, do hereby consent to said Minor participating in all M4 activities including classes, outreaches, camp, and reward trips held in and out of the San Angelo. Which are conducted by: The Garden Apostolic Training Center.

Authorization of Consent to Treatment of Minor:

(I) (We), the undersigned, parent(s) of _____, a minor, do hereby authorize M4 Initiative /The Garden Apostolic Training Center, hereinafter "Agent", for and on behalf of the undersigned to consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment, and hospital care which is deemed advisable by, and is to be rendered under the general or specific supervision of any physician and surgeon licensed under the provision of the Medical Practice Act, whether such diagnosis or treatment is rendered at the office of said physician or at a hospital, during all times that the Minor is in the presence of said Agent.

It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required, but is given to provide authority and power on the part of our aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment, or hospital care which the aforementioned physician in the exercise of his best judgment may deem advisable.

HIPAA Release Authority. My agent shall be treated as I would be with respect to my rights regarding the use and disclosure of my child's individually identifiable health information or other medical records. This release authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 U.S.C. 1320d and 45 CFR 160 through 164. I authorize any physician, health care professional, dentist, health plan, hospital, clinic, laboratory, pharmacy, or other covered health care provider, any insurance company, and the Medical Information Bureau, Inc. or other health care clearinghouse that has provided treatment or services to my child, or that has paid for or is seeking payment from me for such services, to give, disclose and release to my agent, without restriction, all of my child's individually identifiable health information and medical records regarding any past, present or future medical or mental health condition, including all information relating to the diagnosis of HIV/AIDS, sexually transmitted diseases, mental illness, and drug or alcohol abuse. The authority given my agent shall supersede any other agreement that I may have made with my child's health care providers to restrict access to or disclosure of my child's individually identifiable health information.

This authorization shall remain effective until terminated in writing.

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Release of _____: (child's name)

_____ (Parents) shall indemnify, hold free and harmless, assume liability for, and defend The Garden Apostolic Center, its agents, servants, employees, officers, and directors from any and all liability for personal injury or property damage and costs and expenses including but not limited to, attorney's fees, reasonable investigative and discovery costs, court costs, and all other sums for any claim or action founded thereon, arising or alleged to have arisen out of _____ (child's name) use of the real or personal property belonging to or used by Agent while Minor is in the presence of Agent.

Parent _____ Date: _____
Signed

Parent _____ Date: _____
Signed

M4 Media Release

While participating with M4, staff of the M4 and media representatives may want to interview, photograph or videotape your child for use in publications, television reports, public presentations and websites. The pictures may be of groups of students or individuals, and the students' names may be used. For student protection online, a student's photo and last name will not appear together on M4 and Garden related websites. Please complete the section below.

Please check one:

- I give permission for my child to be photographed/videotaped and interviewed and permission to have my child's name used. Only first names will be used on M4 or Garden websites.
- I give permission for my child to be photographed/videotaped, but **do not** want my child's name used
- I **do not** want my child photographed/videotaped or interviewed and do not want his or her name used

_____ Child's Name(s) _____

_____ Parent/Guardian Signature _____ Today's Date _____

**LIMITED LIABILITY FOR HUNTING AND OTHER RECREATIONAL
ACTIVITIES**

AGREEMENT AND WARNING

I UNDERSTAND AND ACKNOWLEDGE THAT AN AGRITOURISM ENTITY IS NOT
LIABLE FOR ANY INJURY TO OR DEATH OF AN AGRITOURISM PARTICIPANT
RESULTING FROM AGRITOURISM ACTIVITIES. I UNDERSTAND THAT I
HAVE ACCEPTED ALL RISK OF INJURY, DEATH PROPERTY DAMAGE, AND OTHER
LOSS THAT MAY RESULT FROM AGRITOURISM ACTIVITES.

This must (a) be signed before the participant is engaged in the activity and (b) if the participant is a minor the
minor's parent, managing conservator or guardian must sign.

Participant Signature: _____

Parent/Guardian/Managing Conservator: _____