Event: *Fayetteville ComicCon 2019*
Location: *Crown Center Exhibition Center*
Date: *Saturday, October 19, 2019*
Registration Deadline: *Monday, October 14, 2019*
Cost: *$15*

_____
Church / Group Name

PARTICIPANT INFORMATION

Participant Name: _____

Date of Birth: _____

PARENT / GUARDIAN INFORMATION

Parent / Guardian Name: _____

Phone Number: _____

Parent / Guardian Name: _____

Phone Number: _____

NON-PARENT EMERGENCY CONTACT

Contact Name: _____

Phone Number: _____

PLEASE READ AND INTIAL THE FOLLOWING

_____ **(INITIAL)** I give permission for _____ **(PRINT CHILD'S NAME)** to attend said event at the location and on the dates listed above.

_____ **(INITIAL)** I understand that Saint Elizabeth Ann Seton Catholic Church and the Diocese of Raleigh are committed to providing fun, safe, educational experiences and that all events are conducted in smoke-, alcohol-, and drug-free environments.
In light of this, and to help ensure the safety of all concerned, I understand that if my child is in possession of tobacco / vape products, alcohol, or any form of illegal drugs or if they engage in immoral, illegal or offensive behavior, or refuses to follow directions given by staff or volunteers while participating in the event, I will be contacted to come pick up my child at my expense.

_____ **(INITIAL)** I understand that photographs, both individual and group, maybe taken during this event. I acknowledge and accept that those photographs may be used for promotional / informational purposes following the event.

_____

SIGNATURE OF PARENT / GUARDIAN and DATE

MEDICAL INSURANCE INFORMATION
IF NO INSURANCE, PLEASE CHECK HERE ☐

Medical Insurance Issued By: _____

Policy Holder / Subscriber Name: _____

Policy Number: _____

MEDICAL HISTORY

Please list all allergy and dietary restrictions. If none are present, please write 'None': _____ _____ _____ _____

Please list all existing medical conditions for the participant. If none are present, please write 'None'. _____ _____ _____ _____

MEDICAL TREATMENT PREFERENCES

I hereby grant permission to any staff person to provide the following over-the-counter medications to my child. (Check all that apply)

☐Tylenol ☐Benadryl ☐Advil/Midol ☐Sudafed ☐Sunscreen
☐Pepto-Bismol ☐Neosporin ☐Kaopectate ☐Imodium ☐Other

If Other: _____

I give my permission for my child, in case of an emergency, to be taken to a physician or hospital by either the supervisor in charge or by an adult chaperone. I understand that every effort will be made to contact me. If I cannot be reached, however, I hereby give permission to the physician selected by the supervisor in charge or adult chaperone(s) to hospitalize and secure proper treatment (including surgery) for my child. The cost of any necessary medical care or treatment for my son/daughter will be my expense.

I acknowledge that if any information changes, it my responsibility to inform parish / diocese.

_____

SIGNATURE OF PARENT / GUARDIAN and DATE