

PARENTAL

PARENTAL/ GUARDIAN CONSENT FORM

And

LIABILITY WAIVER

Participant's name: _____
Birth date: _____ Sex: ___ Parent/Guardian's name: _____
Home address: _____
Home phone: _____ Daytime Phone _____

I, _____, grant permission for my child, _____, (Parent or guardian's name) (child's name)

to participate in _____ that requires transportation to _____ and back to Mahnomen. This activity will take place under the guidance and direction of community volunteers.

- Type of event:**
- Location of event:**
- Individual in charge:**
- Date of event:**
- Mode of transportation from St. Michael's:**

As a parent and/or legal guardian, I remain legally responsible for any personal actions taken by the above named minor (participant). I agree on behalf of myself, my child named herein, or our heirs, successors, and assigns, to hold harmless and defend The Catholic Community of St. Joseph and St. Michael, its officers, directors and agents, chaperones, or representatives associated with the event, arising from or in connection with my child attending the event or in connection with any illness or injury or cost of medical treatment in connection therewith, and I agree to compensate The Catholic Community of St. Joseph and St. Michael, and its officers, directors and agents, chaperons or representatives associated with the event for reasonable attorney fees and expenses arising in connection therewith.

Signature: _____ **Date:** _____

MEDICAL MATTERS

I hereby warrant that to the best of my knowledge, my child is in good health, and I assume all responsibility for the health of my child.

*(Of the following statements pertaining to medical matters, sign **only** those that are applicable.)*

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Emergency Medical Treatment:

In the event of an emergency, I hereby give permission to transport my child to a hospital for emergency medical or surgical treatment. I wish to be advised prior to any treatment by the hospital or doctor. In the event of an emergency, if you are unable to reach me at the above numbers, contact:

Name & Relationship: _____

Phone: _____ Family doctor: _____ Phone: _____

Family Health Plan Carrier: _____

Policy #: _____

Signature: _____ **Date:** _____

Special Medical Information :

Allergic reactions (medications, foods, plants, insects, etc.): _____

Has child recently been exposed to contagious disease or conditions, such as mumps, measles, chicken pox, etc.?

Yes No If yes, date and disease or condition: _____

You should be aware of these special medical conditions of my child:
