Fiat Days Camp 2013 PERMISSION SLIP

Location: Our Lady of Mattaponi Youth Retreat and Conference Center, 11000 Mattaponi Road, Upper Marlboro, MD 20772
Date: Tuesday, July 30, 2013 10am through Wednesday, July 31, 2013 2pm
Transportation: Participants are to arrange their own transportation to/from this event.
Cost: $50 (checks payable to St Peters)
Mail form and payment to: Angela Busby, St. Peters Parish, 2900 Olney-Sandy Spring Road, Olney, MD 20832

Participant's name: _____

Parent/Guardian's name: _____

Date of birth: _____/_____/_____ Email:_____

Home address: _____

Home phone: _____ Cell phone:_____

I, _____ grant permission for my child, _____
Parent's name Child's name
to participate in this archdiocesan event to be held at Our Lady of Mattaponi Youth Retreat and Conference Center. This activity will take place under the guidance and direction of nuns, employees and/or volunteers from the Archdiocese of Washington. As 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 Archdiocese of Washington, its officers, directors, employees and agents, chaperons, or representatives associated with the event, from any claim arising from or in connection with my child attending the event or in connection with any illness or injury (including death) or cost of medical treatment in connection therewith, and I agree to compensate the Archdiocese of Washington, its employees and agents and chaperons, or representative associated with the event for reasonable attorney's fees and expenses which may incur in any action brought against them as a result of such injury or damage, unless such claim arises from the negligence of the archdiocese.

Signature: _____ Date: _____

Medical Matters
Participant's name:_____ 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:****

I. 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 further 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: _____

II. Other Medical Treatment

In the event it comes to the attention of the Archdiocese of Washington, chaperons, or representatives associated with the activity that my child becomes ill with symptoms such as headache, vomiting, sore throat, fever, diarrhea, I want to be called collect (with phone charges reversed to myself).

Signature: _____ Date: _____

III. Medications

My child is taking medication at present. My child will bring all such medications necessary, and such medications will be well-labeled. Names of medications and concise directions for seeing that the child takes such medications, including dosage and frequency of dosage, are as follows:_____

_____

Signature: _____ Date: _____Medical

I hereby grant permission for non-prescription medication (such as non-aspirin products, i.e. acetaminophen or ibuprofen, benedryl, throat lozenges, cough syrup) to be given to my child, if deemed appropriate.

Signature: _____ Date: _____

No medication of any type, whether prescription or non-prescription, may be administered to my child unless the situation is life-threatening and emergency treatment is required.

Signature: _____ Date: _____

IV. Specific Medical Information

The archdiocese will take reasonable care to see that the following information will be held in confidence:

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

_____

Immunizations: Date of last tetanus/diphtheria immunization:_____

Does child have a medically prescribed diet?_____

_____

Any physical limitations?_____

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

_____

Signature: _____ Date: _____