CATHOLIC MUTUAL "CARES" LOSS PREVENTION SYSTEM
PARENT/GUARDIAN CONSENT FORM AND LIABILITY WAIVER

Curriculum Goal: **St. Vincent de Paul School Green Team Grades 4 – 8**
Destination: **School Room 250**
Designated Supervisor of Activity: Mrs. Molly Kain, Mrs. Jen Schaust, Mrs. Kathy Cook,
Wednesdays: 9/30/15, 10/28/15, 11/18/15, 1/20/16, 4/20/16,5/11/16 and Saturday 2/6/15
***** Please bring your own snack in a reusable container****
Date and Time: **1:40 PM – 3:00PM: Parents pick up students @ school**
Student Cost: **-0-** Unlimited Participants

I _____hereby grant my permission for my child, _____, _____
(Parent or guardian's name) (Child's Name) (Teacher-grade
to participate in the above named activities including the method of transportation. In consideration of my child's participation, I agree to indemnify St. Vincent de Paul parish/school and the Archdiocese of St. Paul/Minneapolis from any claims or lawsuits brought against St. Vincent de Paul parish/school/Archdiocese of St. Paul/Minneapolis by myself, my child or others, that arises out of any behavior by my child at the event/activity described above. I also agree to pay reasonable attorney's fees or expenses incurred by the parish/school and Archdiocese in defense of such a claim/lawsuit.

I understand that this event will take place away from the school grounds and that my child will be under the supervision of the St. Vincent de Paul School employee and/or volunteers.

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.
EMERGENCY MEDICAL TREATMENT: In the event of an emergency, I hereby give permission to transport my child to a hospital for emergency medical treatment. I wish to be advised prior to any further treatment by the hospital or doctor.

Hospital (Preferred)_____

Family doctor: _____Phone: _____

Family Health Plan Carrier:_____ Policy #: _____
In event 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). 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.

SPECIAL MEDICAL INFORMATION:
Allergic reactions (medications, foods, plants, insects, etc):_____

Any physical limitations?_____

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

X_____ _____
Parent/Guardian's Signature **Date**
Home address:_____

Home phone:_____ Work Phone_____

Emergency Phone:_____ E-mail:_____
In the event of an emergency, if you are unable to reach me at the above numbers, contact (emergency name)

_____ Phone:_____
_____ I can volunteer to help (Screened Volunteers only) **_____ I cannot volunteer**

STUDENT: By signing this consent form I agree to abide by St. Vincent de Paul's Code of Conduct described in the School Handbook.
X_____ _____ _____
(Student Signature) **(Date)** **(Teacher/Grade)**

PLEASE RETURN THIS FORM BY: Monday, September 28th, 2015