

**PARENT / LEGAL GUARDIAN PERMISSION SLIP  
AND INDEMNITY AGREEMENT**

**PLEASE RETURN BY:** Permission slip required for Go MAD Summer Service Tuesdays 2014

Child / Ward: \_\_\_\_\_ Grade \_\_\_\_\_

Parish / School: St Mary Hales Corners \_\_\_\_\_

Designated Supervisor of Activity: Pam Lownik

**Activity:** Teen Spark Summer Service Tuesdays 4:30-8:00pm (fill in date below)

**Date(s) and time of activity:** \_\_\_\_\_

**Prayer:** Appropriate to the theme of the evening

**Service Immersion:** Each week we will be doing a specific job at various sites.

**Relevant Dialogue:** We will discuss Catholic Social Teaching principles appropriate to the evening.

**Social Activities:** Open gym or outside kick ball, capture the flag, and treat.

I consent to the participation of my child/ward in the above named activity. In consideration for my child/ward's participation, I agree to reimburse and indemnify the parish/school (understood to include the Archdiocese of Milwaukee) for all reasonable legal and court fees incurred by parish/school in defending a lawsuit that I or my child/ward may bring against the parish/school which relates to the above named activity if the parish/school is found not legally liable by the courts and prevails in the lawsuit. If the parish/school is found legally liable for injuries sustained by child/ward, this paragraph will not apply.

I certify that I have an understanding of this agreement and any risks and hazards associated with the activity described above that my child/ward will be participating in. I further understand that I had the opportunity to fully discuss this agreement with a representative of the parish/school to clarify any concerns or questions about the activity or this agreement that I may have had.

\_\_\_\_\_  
Parent / Legal Guarding Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Address

\_\_\_\_\_  
Home phone/ Work phone

**EMERGENCY MEDICAL TREATMENT:** In the event of an emergency, I 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. In the event of an emergency, if you are unable to reach me at the above numbers, contact:

Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Please furnish medical information about your child/ward, which may be pertinent to his or her participation in the above-identified activity: \_\_\_\_\_

This form has been prepared by and is required by The Archdiocese of Milwaukee's Protected Self-Insurance Program. Questions should be directed to Catholic Mutual Group at 255-6906.  
6153(b) Archdiocese of Milwaukee