

PARENT / LEGAL GUARDIAN PERMISSION SLIP & INDEMNITY AGREEMENT

PLEASE RETURN Form by: April 1, 2015

To Lumen Christi Catholic Formation Office
138 W. Buntrock Avenue, Thiensville, WI 53092

→ Name of Child/Ward: _____

Parish/School: Lumen Christi Parish Outreach, 138 W. Buntrock Ave, Thiensville, WI 53092

Designated Supervisor of Activity: Kelly Lemens, Outreach Coordinator

Activity: Youth Outreach Program

→ Mission Site and Dates: Place: St. Joseph, MI From: July 6, 2015 To: July 10, 2015

Method of Transportation: Van/Car transportation

Student Cost (if applicable): \$400

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 and legal 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 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 Guardian Signature

Date

Address – STREET

Home Phone

Address -- CITY & ZIP

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: _____

Please furnish medical information about your child/ward which may be pertinent to his or her participation in the above indemnified 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 262-255-6906.

PHOTO PERMISSION: I hereby grant the release and use of any photo/image taken of my son/daughter _____ for promotion of our programs. _____ (Parents' initials)

Parental/Guardian Consent Form and Liability Waiver

Parent Name & Relationship: _____
Phone: _____ Family Doctor: _____ Phone: _____
Family Health Plan Carrier: _____
Policy # _____ Group # _____

Signature: _____ Date: _____

Other Medical Treatment: In the event it comes to the attention of the program directors or volunteers that my child becomes ill (headache, vomiting, sore throat, fever, diarrhea), I want to be called immediately.

Signature _____ Date: _____

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: _____

Sign ONE in this box which applies

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: _____

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

Signature: _____ Date: _____

Specific Medical Information: The parish 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? _____

Is child subject to chronic homesickness, emotional reactions to new situations, sleepwalking, bedwetting, fainting? _____

Has child recently been exposed to contagious disease or conditions, such as mumps, measles, chickenpox, etc? _____

If so, date and disease or condition: _____

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

