

**ARCHDIOCESE OF SAN FRANCISCO / PARENTAL PERMISSION FORM**

**ACTIVITY:** On **Thursday, April 24 and Friday April 25, 2008** your son will participate on a retreat at the Mission Springs Conference Center in Scotts Valley, located at 1050 Lockhart Gulch Road. He must be at the school no later than 8:15 AM on Thursday and will return to school by 2:30 PM on Friday. This retreat experience is optional (not required) and will include both low and high ropes course activities. The cost is \$100.00, which includes three meals, snacks, lodging, transportation, and instruction on and supervision of the ropes course activities. He will also need money for lunch on Friday on the way home.

**STUDENT** \_\_\_\_\_ **BIRTHDATE** \_\_\_\_\_

**ADDRESS** \_\_\_\_\_ **(Street, City, Zip)**

**PARENT/GUARDIAN NAME** \_\_\_\_\_

**ADDRESS** \_\_\_\_\_

**PHONE** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
**HOME WORK CELL**

**IF I CANNOT BE CONTACTED IN CASE OF EMERGENCY, PLEASE CONTACT THE FOLLOWING PERSON(S): (Please list people you expect to be available that day.)**

\_\_\_\_\_  
**NAME PHONE NUMBER(S)**

\_\_\_\_\_  
**NAME PHONE NUMBER(S)**

I, the parent (guardian) of the above named child, hereby, give my permission for his/her participation in the activity named above. I agree to direct my child to cooperate and conform with the directions and instructions of the parish, school or Archdiocesan personnel responsible for the activity.

I agree, to the extent permitted by law, that in the event my child is injured as a result of his/her participation in the above named activity, including but not limited to transportation to and from the activity, whether or not caused by the negligence (active or passive) of the parish/school or Archdiocesan youth activities program, or any of its agents or employees, recourse for the payment of any resulting hospital, medical, or related costs and expenses will first be had against any accident, hospital or medical insurance, or any available benefit plan of mine or my spouse.

I am not aware of any medical condition of my child which would render it inappropriate for him to participate in any such activity.

I, hereby, give permission to the physician selected by the youth activities supervisory personnel then present to render medical treatment deemed necessary and appropriate by the physician.

\_\_\_\_\_  
**MEDICAL INSURANCE CARRIER/CO. ID or POLICY #**

\_\_\_\_\_  
**Parent/Guardian Signature Date**

\_\_\_\_\_  
**Parent/Guardian Signature Date**