St. Peter's/St. Mary's 2010 Confirmation Retreat

PARENT / LEGAL GUARDIAN PERMISSION SLIP AND INDEMNITY AGREEMENT

CHILD / WARD: ____

PARISH: ST. PETER'S OF ALCANTARA AND ST. MARY'S, PORT WASHINGTON

SUPERVISOR OF ACTIVITY: YOUTH MINISTER AND CONFIRMATION TEAM

ACTIVITY: Confirmation retreat at Daniel Soref Retreat Center, Fredonia

DATE(S) AND TIME OF ACTIVITY: GROUP A: MARCH 6-7 GROUP B: MARCH 13-14;

LEAVE ST PETER'S SATURDAY 7:30 AM, RETURN IN TIME FOR SUNDAY MASS

METHOD OF TRANSPORTATION: BUS

STUDENT COST: N/A

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 Guardian Signature Date

____ _____________/_______________

Address Home phone / Cell 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:

____

The other side of this form must be filled out and signed

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 414-255-6906.

MEDICAL RELEASE FORM

PARTICIPANT'S NAME:_____________________________BIRTHDATE:_____________ SEX: __________

FAMILY DOCTOR: ______________________________ PHONE: (_____)______________________________

Family Health Plan Carrier: _________________________ Policy Number: _______________________________

MEDICAL MATTERS: I hereby warrant 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 IN ACCORDANCE WITH YOUR WISHES.

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: ____

HOME PHONE: (______)____________________ BUSINESS PHONE: (______)________________________

Signature ____ Date ___________________________________

Other Medical Treatment: In the event it comes to the attention of DESIGNATED SUPERVISOR or staff that SON/DAUGHTER/WARD becomes ill with symptoms of headache, vomiting, sore throat, fever, or diarrhea, I DO want to be called collect (with phone charges reversed to myself if necessary).

Medications: SON/DAUGHTER/WARD is taking medications at present and will bring all such medications necessary, and such medications will be well labeled. I give permission for SON/DAUGHTER/WARD TO TAKE THIS MEDICATION ON HIS/HER OWN. The dosage and frequency of dosage is as follows:

____

Signature ____ Date ___________________________________

If requested, I DO give permission for SON/DAUGHTER/WARD to be given the following (circle):

Aspirin	Benedryl	Midol	Ibuprofen	Pepto Bismo	Cough drops
Aspicream	Tums	Sudafed	Primatene Mist	Tylenol	Other _______________

Signature ____ Date ___________________________________

No Medication of Any Type: whether prescription or nonprescription may be administered to my SON/DAUGHTER/WARD unless the situation is life threatening and emergency treatment is required.
Signature ____ Date ___________________________________

Specific Medical Information: The parish/school 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 to these special medical conditions of my child: ____________________________________

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 414-255-6906.