

Diocese of Superior
Parent or Legal Guardian Permission Slip and Indemnity Agreement

Please return this form to the appropriate parish/school/diocesan personnel by the date indicated below.

Child's Full Legal Name:

Child's Date of Birth: _____

Gender: _____

Child's Address:

Your child (named above) is eligible to participate in a school/parish-sponsored activity that requires your permission. This activity will take place under the guidance and supervision of employees and/or volunteers from St. Patrick Parish, Hudson, WI.

To participate in this activity, this completed and signed permission form must be returned to: no later than

A brief description of the activity is as follows:

Type of activity: **Confirmation Bootcamp**

Description of activity:

This will be an overnight retreat experience where the youth will be prepared for confirmation, educated on what gifts it will provide, and be provided with an opportunity to open themselves up to the gifts of the holy spirit. Between the talks, prayer time, and the Sacraments we are hoping that this camp will be extremely empowering for our future Confirmed Catholics

Date and time of activity: We will **arrive 10:30am Jan 6th and depart 1pm Jan 7th**

Method of transportation: Bus, We will all ride together to the campsite

Student cost: 100\$ per student

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 above named parish/school/Diocese of Superior (DOS) for all reasonable legal and court fees incurred by parish/school/DOS in defending a lawsuit that I or my child/ward may bring against the parish/school/DOS which relates to the above named activity if the parish/school/DOS is found not legally liable by the courts and prevails in the lawsuit. If the parish/school/DOS is found legally liable for the injuries sustained by my child/ward, this paragraph will not apply. I further agree to reimburse the diocese or any other agency for property damage or any bodily harm to other participants caused by my child/ward.

I certify that I have an understanding of this agreement, as well as the risks and hazards associated with the activity (including illness, injury and the rare possibility of death) 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/DOS to clarify any concerns or questions about the activity or this agreement that I may have had.

Parent or guardian signature: _____ Date:

Address of parent or legal guardian:

Phone numbers - Home: _____ Work: _____ Cell: _____

Email: _____

This is a two-sided form. Please complete both sides. 55-A Front
August 2009

Emergency and Incidental 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, please contact:

Name: _____

Relationship: _____

Phone numbers - Home: _____ Work: _____

Cell: _____

I further understand that if I cannot be reached, or if the emergency contact that I have listed above cannot be reached, and my child/ward is in need of immediate medical care, the parish/school/DOS reserves the right to make a temporary decision that is in the best interest of my child/ward until such a time when I can be reached.

Please check the appropriate preference below.

I give permission to chaperones of this event from the parish/school/DOS to distribute non-prescription/ over-the-counter medications and treatments to my child/ward such as, but not limited to: applying minor bandages and first-aid ointments or sprays, ice or heat compresses, dispensing of non-aspirin pain relievers, cough drops or syrups, and antacids and the like.

Yes ___ No ___

Please supply all of the information requested below:

Family Health Insurance Company:

Policy # :

Family physician or clinic: _____

Address: _____

Phone: _____

Family dentist: _____

Address: _____

Phone: _____

Date of most recent
physical examination: _____

Current medications: _____

Date of most recent tetanus immunization: _____

Known allergies: _____

Treatment for allergies: _____

Recent surgeries or serious illness: _____

Any other special needs to be noted:

I verify that all of the medical information for my child/ward listed above is correct and current to the best of my knowledge at the time of the event described above. I have indicated all potential health issues for my child/ward (including medications and any special dietary needs), as well as indicated my preference to the distribution of non-prescription/over-the-counter medications and treatments such as: applying minor bandages and first-aid ointments or sprays, ice/ heat compresses, dispensing of non-aspirin pain relievers, cough drops or syrups, and antacids and the like.

Parent or guardian signature: _____

Date: _____

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