FORM 13

FIELD TRIP PERMISSION FORM

ARCHDIOCESE OF WASHINGTON – Catholic Schools

Participant's Name: _____ Sex: ☐ ☐ Birth Date: _____
Print Student's Legal Name *Male* *Female* *mm/dd/yyyy*

Parent/Guardian Name: _____

Home Address: _____

_____

Home Phone: **( ) -** _____ Alt. Phone: **( ) - Ext.** _____

Consent and Release of Liability

I, _____, grant permission for my child, _____ ,
Parent/Guardian's Full Name *Print Student's Name*
to participate in this school event that may require transportation to a location away from the school site. This activity will take place under the guidance and direction of school employees and/or volunteers from **St Jude Regional Catholic School**.

A brief description of the activity follows:

Type of Event: _____

Date of Event: _____

Estimated Time of Departure from School: _____ Estimated Time of Return to School: _____

Destination of Event: _____

Individual In-charge: _____

Mode of Transportation To/From Event: _____

As parent and/or guardian, I remain legally responsible for any personal actions taken by the above named minor ("participant").

I agree on behalf of myself, my child named herein, or our heirs, successors, and assigns, to hold harmless and defend **St Jude Regional Catholic School**, its parish, officers, directors, employees and agents, and the Archdiocese of Washington, its employees and agents, chaperons, or representatives associated with the event, from any claim arising from or in connection with my child attending the event or in connection with any illness or injury (including death) or cost of medical treatment in connection therewith, and I agree to compensate the parish, its officers, directors and agents, and the Archdiocese of Washington, its employees and agents and chaperons, or representative associated with the event for reasonable attorney's fees and expenses which may incur in any action brought against them as a result of such injury or damage, unless such claim arises from the negligence of the parish/diocese.

Name of Parent/Guardian: _____
Print Parent/Guardian Full Name

Signature of Parent/Guardian: _____ **Date** _____
Sign Your Name *Today's Date*

Medical Information and Acknowledgment

Parent/Guardian Acknowledgment: I hereby warrant that to the best of my knowledge, my child is in good health, and I assume all responsibility for the health of my child.

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 non-emergency 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 to Student: _____
Print Full Name of Emergency Contact

Phone No. **( ) -** _____ Alt.Phone No. **( ) - Ext.** _____

Health Care Provider: _____ Policy No.: _____

Primary Physician: _____

Signature of Parent/Guardian: _____ **Date** _____
Sign Your Name *Today's Date*

Non-Emergency Medical Treatment (If Applicable): In the event it comes to the attention of the parish, its officers, directors and agents, and the Archdiocese of Washington, chaperons, or representatives associated with the activity that my child becomes ill with symptoms such as headache, vomiting, sore throat, fever, diarrhea, I want to be notified immediately.

Signature of Parent/Guardian: _____ **Date** _____
Sign Your Name *Today's Date*

Medications (If Applicable): 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:

Provide medication name(s) and dose(s) here: _____

_____

Signature of Parent/Guardian: _____ **Date** _____
Sign Your Name *Today's Date*

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 of Parent/Guardian: _____ **Date** _____
Sign Your Name *Today's Date*

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

Signature of Parent/Guardian: _____ **Date** _____
Sign Your Name *Today's Date*

Specific Medical Information: The 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 the participant have a medically prescribed diet? ☐ NO ☐ YES _____
Any physical limitations? ☐ NO ☐ YES _____
Is child subject to chronic homesickness, emotional reactions to new situations, sleepwalking, fainting? ☐ NO ☐ YES _____
Has the participant recently been exposed to contagious disease or conditions, such as mumps, measles, chicken pox, etc.? ☐ NO ☐ YES Disease: _____ Date: _____

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

_____

_____