CATHOLIC MUTUAL "CARES" LOSS PREVENTION SYSTEM
PARENT/GUARDIAN CONSENT FORM AND LIABILITY WAIVER

Please print and complete one per choral student

Curriculum Goal: **Choral Program**
Destination: **St. Vincent de Paul Church**
Designated Supervisor of Activity: **Jacquie Okoh**
Date and Time: **Mondays - GRADES 6-8, 1:40-2:40 P.M. Starting September 10th**
Tuesdays - GRADES 2-5, 1:40 -2:40 P.M. Starting September 11th

Method of Transportation: **Parents provide transportation home at 2:40 P.M.** Please pick your child up at the Church. If you are late, pick your child up at the school.

I ________________________________hereby grant my permission for my child,_________________________, ____________
(Parent or guardian's name) (Child's Name) (Teacher, Grade)
to participation in the above named activities including the method of transportation. In consideration of my child's participation, I agree to indemnify St. Vincent de Paul parish/school and the Archdiocese of St. Paul/Minneapolis from any claims or lawsuits brought against St. Vincent de Paul parish/school/Archdiocese of St. Paul/Minneapolis by myself, my child or others, that arises out of any behavior by my child at the event/activity described above. I also agree to pay reasonable attorney's fees or expenses incurred by the parish/school and Archdiocese in defense of such a claim/lawsuit.

I understand that this event will take place away from the school grounds and that my child will be under the supervision of the St. Vincent de Paul School employee and/or volunteers.

MEDICAL MATTERS: 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 treatment. I wish to be advised prior to any further treatment by the hospital or doctor.

Hospital (Preferred)____

Family doctor: ____Phone: ______________________

Family Health Plan Carrier:___________________________________ Policy #: ____________________

In event that my child becomes ill with symptoms such as headache, vomiting, sore throat, fever, diarrhea, I want to be called collect (with phone charges reversed to myself). 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.

SPECIAL MEDICAL INFORMATION:
Allergic reactions (medications, foods, plants, insects, etc):_____________________________________

Any physical limitations?____

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

X____ ________________
Parent/Guardian's Signature **Date**

Home address:____

Home #______________________ Work #_____________________ Emergency# __________________

E-mail: ____

In the event of an emergency, if you are unable to reach me at the above numbers, contact:

____ Phone:____________________
(emergency name & relationship)

STUDENT: By signing this consent form I agree to abide by St. Vincent de Paul's Code of Conduct described in the School Handbook.

X____ ______________ ____________
(Student Signature) **(Date)** **(Teacher/Grade)**

PLEASE RETURN THIS FORM BY: BEFORE THE FIRST PRACTICE