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

Curriculum Goal: **Generation Endurance Girl Power….. Girls Grade 5 - 8**
Destination, Date, and Time: **1:45 – 3:30 PM School Gym : December 3, 10, 12, & 17, January 7,9, 14 & 16**
Supervisor of Activity: **Mrs. Baker**
Method of Transportation: **PARENTS PROVIDE TRANSPORTATION**
Student Cost: **$141.00**
MAKE CHECKS PAYABLE TO GENERATION ENDURANCE

**There is no medical insurance provided for this sport. Check with your own insurance company to see if you are covered under your own medical policy.

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)**

PARENT VOLUNTEERS: ____ Yes, I can volunteer _____No I cannot volunteer

PLEASE RETURN THIS FORM AND FEE BY: Monday, December 1, 2014