Date:__________

Amount:_______

Check # _______

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

Curriculum Goal: **Chess Club**
Destination: **St. Vincent de Paul Media Center/Art Room**
Designated Supervisor of Activity: **Kevin Landman - Any questions call 763-420-7202**
Date and Time: **Tuesdays, 1:45 -3:15 p.m. Starting Tuesday, October 21, 2014 – March 17, 2015**
Method of Transportation: **Parents provide transportation home at 3:15 p.m.**
Student Cost: $20.00

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 AND FEE BY: MONDAY, October 20, 2014