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

Destination: **OSSEO PUBLIC LIBRARY/ ST. VINCENT de PAUL CHURCH/STEEPLE POINTE OSSEO STREET/BUSINESSES/PARKS IN OSSEO AND MAPLE GROVE**
Designated Supervisor of Activity: TEACHERS
Date and Time of Departure: **2014-2015 SCHOOL YEAR** DETERMINED BY THE TEACHERS
Date and of Anticipated Time of Return: AS ABOVE
Method of Transportation: WALK
Student Cost: -0-

I __________________________ hereby grant my permission for my child,____________________, _______________
(Parent or guardian's name) (Child's Name) (Teacher's name – grade)

to participate 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 (emergency name & relationship)__________________________________________ Phone:___________________________

**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 August 27, 2014**