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

Curriculum Goal: **Generation Endurance and Shepherds Flock Training –Endurance Training**
Destination, Date, and Time: **School grounds: Tuesdays, September 9, 16, 23, 30, 2014**
***SEE FLYER FOR FURTHER DETAILS***
Designated Supervisor of Activity: **Mrs. Pam Baker**
Method of Transportation: **PARENTS PROVIDE TRANSPORTATION**
Student Cost: **$52.00 per student – 1st -4th Grades (Includes t-shirt)**

**MAKE CHECKS PAYABLE TO GENERATION ENDURANCE**
****There is no medical insurance provided for this activity****

**I,** _____ hereby grant my permission for my child,_____, _____
(Parent or guardian's name) (Child's Name) (Teacher)
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 /volunteers and the Archdiocese of St. Paul/Minneapolis from any claims or lawsuits brought against St. Vincent de Paul parish/school/volunteers/ 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 on and 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 special 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#_____
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)**

**PARENT VOLUNTEER**
**____ Yes, I can volunteer** **_____No I cannot volunteer**

**PLEASE RETURN THIS FORM AND FEE BY: Friday, September 5, 2014**