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

Curriculum Goal: **Developing skills in BOYS MINI-WRESTLING – *GRADES K, 1, 2, and 3***
Destination: **St. Vincent de Paul GYM**
Designated Supervisor of Activity: **Volunteers will coach.**
Date and Time: **April 22, 24,29 & May 1st; 1:45 – 3:30 PM; Little Matman Classic, Saturday May 3rd**

Method of Transportation: **Parents will provide transportation AND/OR WALK**

Student Cost: **$20.00 - Fee includes a Royal Wrestling T-Shirt**

Please circle one size – Youth Med, Youth Large, Youth XL, Adult SM, Adult Med, Adult Large

**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)
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# _____
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 FORMS AND MONEY By Monday, April 21st, 2014