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

Curriculum Goal: **Science Enrichment-Grades 2**
Destination: Eastman Nature Center – Seed Program
Designated Supervisor of Activity: **Mrs. Dammer & Mrs. McDowell**
Date and Time of Departure and Return: **Friday, October 31st, 20 Leave: 9:00 A.M. Return 11:30 AM**

*Screened Chaperones needed

Method of Transportation: **BUS**
Student Cost: **$8.00 ** Field trip fee will be charged on Smart Tuition – Do not send money with the waiver****
Will eat lunch upon return

**** Non Uniform Day****

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# _____
In the event of an emergency, if you are unable to reach me at the above numbers, contact (emergency name & relationship)
_____ Phone:_____

_____ I can Chaperone **_____ I cannot Chaperone**
(Chaperones must be screened)

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 MONEY BY: Friday, October 24, 2014