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

Curriculum Goal: **Language Arts**
Destination: **Stages Theatre "Rudolph the Red-Nosed Reindeer"**
Designated Supervisor of Activity: **Mrs. White and Mrs. Winn**
Date and Time: **Thursday, December 11, 2014 Departure - 9:00 a.m. Return – 12:00 PM**
WEAR UNIFORMS (Students will eat upon return to school.)
Method of Transportation: **Bus**
Student Cost: **$13.00: ** Field trip fee will be charged on Smart Tuition – Do not send money with the waiver****

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, insect, etc):_____

Any physical limitations_____

You should be aware of these special medical conditions:_____

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)**

PLEASE RETURN THIS FORM BY FRIDAY, DECEMBER 5, 2014