

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

Curriculum Goal: **St. Vincent de Paul School Green Team "Let's Get Wastewise" Grades 4 – 8**  
Destination: **School Room 170**  
Designated Supervisor of Activity: Molly McCue, Jen Schaust, Kathy Cook,  
**Monday, January 12, 2015**  
Date and Time: **2:00 PM – 3:30 PM: Parents pick up students @ school**  
Student Cost: **-0- Unlimited Participants**

I \_\_\_\_\_ hereby grant my permission for my child, \_\_\_\_\_, \_\_\_\_\_  
(Parent or guardian's name) (Child's Name) (Teacher-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 phone: \_\_\_\_\_ Work Phone \_\_\_\_\_

Emergency Phone: \_\_\_\_\_ E-mail: \_\_\_\_\_

In the event of an emergency, if you are unable to reach me at the above numbers, contact (emergency name )

\_\_\_\_\_ Phone: \_\_\_\_\_

**I can volunteer to help (Screened Volunteers only)**

**I cannot volunteer**

**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: Monday, January 12, 2015**