

# PAX CHRISTI CATHOLIC CHURCH FIELD TRIP

## PARENTAL/GUARDIAN CONSENT FORM AND LIABILITY WAIVER

Participant's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Parent/Guardian's Name: \_\_\_\_\_

Home Address: \_\_\_\_\_

I, \_\_\_\_\_, grant permission for my child, \_\_\_\_\_,  
(Parent or guardian's name) (Child's Name)

to participate in this parish youth ministry event that requires transportation to a location away from the parish site. This activity will take place under the guidance and direction of parish employees and/or volunteers from **Pax Christi Catholic Church**. A brief description of the activity follows:

**Type of Event:** Youth Group Lock-in  
**Destination of Event:** Pax Christi Catholic Church  
**Individual in Charge:** Naomi Schick  
**Date of Event:** September 9-10, 2016, 8 PM – 8 AM  
**Estimated time of departure and return:** Not leaving church grounds

**Mode of Transportation to and from event:** Not leaving church grounds

As parent and/or legal guardian, I remain legally responsible for any personal actions taken by the above named minor ("participant").

I agree on behalf of myself, my child named herein, or our heirs, successors, and assigns, to hold harmless and defend **Pax Christi Catholic Church**, its officers, directors, and agents, and the **Catholic Diocese of Lexington**, chaperons, or representatives associated with the event, arising from or in connection with my child attending the event or in connection with any illness or injury or cost of medical treatment in connection therewith, and I agree to compensate the parish, its officers, directors, and agents, and the **Catholic Diocese of Lexington**, chaperons, or representatives associated with the event for reasonable attorney's fees and expenses arising in connection herewith.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**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. (Of the following statements pertaining to medical matters, sign only those applicable.)

**Emergency Medical Treatment:** In the event of an emergency, I hereby give permission to transport my child to a hospital for emergency medical or surgical treatment. I wish to be advised prior to any further treatment by the hospital or doctor. In the event of an emergency, if you are unable to reach me at the above numbers, contact:

Name & relationship: \_\_\_\_\_

Phone: \_\_\_\_\_ Family Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

Family Health Plan Carrier: \_\_\_\_\_ Policy #: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Other Medical Treatment:** In the event it comes to the attention of the parish, its officers, directors, and agents, and the **Catholic Diocese of Lexington**, chaperons, or representatives associated with the activity 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).

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Medications:** My child is taking medication at present. My child will bring all such medications necessary, and such medications will be well labeled. Names of medications and concise directions for seeing that the child takes such medications, including dosage and frequency of dosage, are as follows:

\_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I hereby grant permission for non-prescription medication (such as aspirin, throat lozenges, cough syrup) to be given to my child if deemed appropriate.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Specific Medical Information:** The parish will take reasonable care to see that the following information will be held in confidence.

Allergic reactions (medications, foods, plants, insects, etc.) \_\_\_\_\_

Immunizations: Date of last tetanus/diphtheria immunization: \_\_\_\_\_

Does child have a medically prescribed diet? \_\_\_\_\_

Any physical limitations? \_\_\_\_\_

Is child subject to chronic homesickness, emotional reactions to new situations, sleepwalking, bedwetting, fainting? \_\_\_\_\_

If so, please explain: \_\_\_\_\_

Has child recently been exposed to contagious disease or conditions, such as mumps, measles, chickenpox, etc? \_\_\_\_\_

If so, date and disease or condition: \_\_\_\_\_

You should be aware of these special medical conditions of my child: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_