PARENT/LEGAL GUARDIAN PERMISSION SLIP
AND INDEMNITY AGREEMENT FOR ACTIVITY WITH
ST. FRANCIS BORGIA CATHOLIC CHURCH

CHILD/WARD: _____

PARISH: ST.FRANCIS BORGIA **DESIGNATED SUPERVISOR OF ACTIVITY**:

ACTIVITY: Mentor Group Sessions at Mentor Home or at SFB Parish
Dates According to Schedule
Mentor Group Service Project Location/Date/Time To Be Determined

Mentor Group Parish Visit Location/Date/Time To Be Determined

METHOD OF TRANSPORTATION: Carpool/Parent Assistance Appreciated

I consent to the participation of my CHILD/WARD in the above named ACTIVITY. In consideration for my CHILD/WARD's participation, I agree to reimburse and indemnify the PARISH/SCHOOL (understood to include The Archdiocese of Milwaukee) for all reasonable legal and court fees incurred by PARISH/SCHOOL in defending a lawsuit that I or my CHILD/WARD may bring against PARISH/SCHOOL which relates to the above named ACTIVITY if the PARISH/SCHOOL is found not legally liable by the courts and prevails in the lawsuit. If the PARISH/SCHOOL is found legally liable for injuries sustained by CHILD/WARD, this paragraph will not apply.
I certify that I have an understanding of this agreement and any risks and hazards associated with the ACTIVITY described above that my CHILD/WARD will be participating in. I further understand that I had the opportunity to fully discuss this agreement with a representative of the PARISH/SCHOOL to clarify any concerns or questions about the ACTIVITY or this agreement that I may have had.

_____ _____
Parent/Legal Guardian Signature Date

HEALTH FORM

NAME: _____ _____ GENDER_____ BIRTHDATE_____

ADDRESS: _____ PHONE: _____

PARISH/SCHOOL: _____ FAMILY PHYSICIAN OR CLINIC: _____

PHYSICIAN ADDRESS: _____ PHONE: _____

FAMILY HEALTH INSURANCE: _____ POLICY NUMBER: _____

Please list any health information that might be needed by the retreat staff or emergency personnel: allergies, chronic conditions, recent or current illness or injury, tetanus status etc.

_____

_____

Please list any medications that your child will be taking while on the retreat:

_____

_____

EMERGENCY MEDICAL TREATMENT: In the event of an emergency, I give permission to transport my CHILD/WARD to a hospital for emergency medical treatment. I wish to be advised prior to any further treatment by the hospital or doctor.

_____ _____
Parent/Legal Guardian Signature Date

_____ H_____C_____
Address Home & Cell Phone Numbers

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

_____ _____ H_____C_____
Name (Please Print) Relationship to Child Home & Cell Phone Numbers