

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

CHILD/WARD: _____ DATE(S) OF ACTIVITY: 5/19/2018

PARISH: ST. FRANCIS BORGIA DESIGNATED SUPERVISOR OF ACTIVITY: KC Kranich

ACTIVITY: Mr. Bob's Under the Bridge at Kosciuszko Park, Milwaukee WI

METHOD OF TRANSPORTATION: ___carpool_____ STUDENT COST (IF APPLICABLE): no cost

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

Address

H _____ C _____
Home & Cell Phone Numbers

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

Name (Please Print)

Relationship to Child

H _____ C _____
Home & Cell Phone Numbers