

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

CHILD/WARD: \_\_\_\_\_ DATE(S) OF ACTIVITY: 7/30/2019

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

ACTIVITY: High School Summer Hiking Prayer Retreat on the Oak Leaf Trail - 8am – 4pm

METHOD OF TRANSPORTATION: Bus COST: please pay online the \$35 retreat fee: [www.saintfrancisborgia.org](http://www.saintfrancisborgia.org)

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