

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

Curriculum Goal: **Developing skills in GIRLS SOFTBALL**
Destination: **To and from school yard and games**
PARENTS ARE RESPONSIBLE FOR TRANSPORTATION BOTH WAYS TO PRACTICE OR GAMES.

Designated Supervisor of Activity: **Volunteers will coach.**
Date and Time: **Afternoons / early evenings in, MARCH, APRIL, MAY 2008**

Method of Transportation: **Parents will provide transportation AND/OR WALK**
Student Cost: **\$55.00** (Please be aware that this is a non-refundable fee. If you or your child decides after signing up they no longer want to play, the fee is not refundable.)

****There is a \$40.00 deposit on all uniforms. This deposit will be returned when the uniform is returned on a hanger with the students name on it.**

See School Handbook re: Extra Curricular Activities.
**There is no medical insurance provided for this sport. Check with your own insurance company to see if you are covered under your own medical policy.
____ Check if need financial assistance

I _____ hereby grant my permission for my child, _____, _____
(Parent or guardian's name) (Child's Name) (Teacher)
to participation 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 #: _____ Work # _____ Emergency# _____
In the event of an emergency, if you are unable to reach me at the above numbers, contact (emergency name & relationship) _____ Phone: _____

See attached forms to sign
PLEASE RETURN FORMS AND MONEY TOGETHER BY: **MONDAY, MARCH 31st**