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

Curriculum Goal: **Literature Enrichment**
Destination: **Totino Grace "Pinocchio"**
Designated Supervisor of Activity: **Mrs. Schlicksup and Mr. Frels Grade 1**
Date and Time: **Wednesday, April 30th, 2008** **Leave 9:15 A.M. and Return at 11:30 A.M.**
Method of Transportation: **Bus**
Student Cost: **$3.75** **** WEAR UNIFORMS****
Student will eat Hot Lunch Upon Return

_____ Money enclosed
_____ Take money from family account
____ Check if need financial assistance

I _____ hereby grant my permission for my child,_____, _____
(Parent or guardian's name) (Child's Name) (Teacher)
to participate 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:_____

STUDENT: By signing this consent form I agree to abide by St. Vincent de Paul's Code of Conduct described in the School Handbook. **X**_____ _____ _____
(Student Signature) **(Date)** **(Teacher/Grade)**

PLEASE RETURN THIS FORM BY: Wednesday, April 23rd , 2008