

\$110
due July 27th



SS John and Paul Parish

PARISH EVENT/TRIP PARENTAL PERMISSION & MEDICAL RELEASE FORM

Child's Name _____ Age _____ Sex _____

Parishioner Non Parishioner, Friend of _____

Address _____ City _____ State _____ Zip _____ Home Phone _____

School _____ Grade _____ Birth Date _____ E-Mail _____

6:30AM 7/31/10 – 11:00PM 8/1/10 _____ Cedar Point and Soak City Overnight

Date(s) of Event _____ Time(s) of Event _____ Description/name of Event/Trip Including Location(s) to be visited _____

Chaperones Needed: Can a parent chaperone or assist? No Yes – Parent Name _____

Is the parent Safe Environments Compliant? No Yes Not Sure

Permission for Child to Participate

I/we, the parents or guardians of the above mentioned child, for myself/ourselves and for my/our child. Give permission for my/our child to participate in the above mentioned event/trip on the above written date.

Medical Authorization

In the event of any injury or illness to my/our child during his/her participation in this one-day (or less) program, I/we hereby give my/our permission for the necessary medical treatment to be given to my/our child. I/we agree that in case of injury to my/our child, we will apply my/our hospitalization and/or or accident insurance toward payment of the expenses incurred and will not look to the SS John & Paul Parish or any other program sponsor or volunteer for the payment of any medical costs or injury related costs.

Parent/Guardian Signature(s) _____ Name(s) (Please Print) _____ Date _____

Phone number(s) for emergency _____

Insurance Company _____ Policy and/or ID number(s) _____

Name and phone number of person to call if parent is not available. _____

ATTENTION: PLEASE COMPLETE REVERSE SIDE ALSO!

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Child's Name _____ Home Phone _____

CONSENT TO TREAT

I/We, the undersigned parent(s)/guardian of _____, a minor, do hereby authorize treatment of my/our child by a licensed medical physician in case of any accident or illness that may so arise, or any hospitalization necessary. This medical consent will remain effective until **(date)** _____.

Signature Father/Legal Guardian Date Phone(s) where you can be reached

Signature Mother/Legal Guardian Date Phone(s) where you can be reached

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. *(Of the following statements pertaining to medical matters, sign only those in accordance with your wishes.)*

1) Medications: My child is **taking medication at present**. My child will bring all such medications necessary, and such medications will be well labeled. My child will be responsible to administer his/her own medication.

Name of medication, time, and dosage _____

Signature _____ Date _____

2) I hereby **grant permission for nonprescription medication** (such as Tylenol, throat lozenges, cough syrup) to be given to my child if deemed advisable.

Signature _____ Date _____

3) **No medicating 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.

Signature _____ Date _____

Known allergies: _____

Known physical limitations: _____

Medically prescribed dietary needs: _____

Is child a vegetarian? No Yes

Is child subject to chronic homesickness, emotional reactions to new situations, sleepwalking, fainting? No Yes

Does child have any other special needs? No Yes – Please briefly describe _____

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