SAINT PETER'S YOUTH MINISTRY

PERMISSION SLIP

Event	Fall Retreat
Location	Claggett Retreat Center
Date & Time	December 8-10, 2017 Leave 6pm PH parking lot/Return 3:30 pm PH parking lot
Transportation	Bus
Cost	$115
Contact	Angela Busby 301-570-4952 angela.busby@stpetersolney.org

Participant's name: _____Participant's Cell: _____

Birth date: _____ Sex: _____

Parent/Guardian's name: _____

Home address: _____ City/St/Zip _____

Parent email: _____

Home phone : _____ Cell phone:_____

I, _____ grant permission for my child,
Parent's name
_____ to participate in this parish
Child's name
event that requires transportation to a location away from the parish site. This activity will take place under the guidance and direction of parish employees and/or volunteers from Saint Peter's Catholic Church.
As parent and/or legal guardian, I remain legally responsible for any personal actions taken by the above named minor ("participant"). I agree on behalf of myself, my child named herein, or our heirs, successors, and assigns, to hold harmless and defend Saint Peter's Church, its officers, directors, employees and agents, and the Archdiocese of Washington, its employees and agents, chaperons, or representatives associated with the event, from any claim arising from or in connection with my child attending the event or in connection with any illness or injury (including death) or cost of medical treatment in connection therewith, and I agree to compensate the parish, its officers, directors and agents, and the Archdiocese of Washington, its employees and agents and chaperons, or representative associated with the event for reasonable attorney's fees and expenses which may incur in any action brought against them as a result of such injury or damage, unless such claim arises from the negligence of the parish/diocese.

Signature: _____ Date: _____

Further, I agree that my child's picture may be used to promote youth ministry events through flyers, brochures and on social media/website.

Signature: _____ Date: _____

***** SEE OTHER SIDE FOR MEDICAL INFORMATION *****

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 that are applicable.)

1. Emergency Medical Treatment: In the event of an emergency, I hereby give permission to transport my child to a hospital for emergency medical or surgical treatment. I wish to be advised prior to any further treatment by the hospital or doctor. In the event of an emergency, if you are unable to reach me at the above numbers, contact:
Name & relationship: _____
Phone: _____ Family doctor: _____ Phone: _____
Family Health Plan Carrier: _____ Policy #:_____
Signature: _____ Date: _____

2. Other Medical Treatment: In the event it comes to the attention of the parish, its officers, directors and agents, and the Archdiocese of Washington, chaperons, or representatives associated with the activity 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).
Signature: _____ Date: _____

3a. Medications: My child is taking medication at present. My child will bring all such medications necessary, and such medications will be well-labeled. Names of medications and concise directions for seeing that the child takes such medications, including dosage and frequency of dosage, are as follows:
_____
_____
Signature: _____ Date: _____

3b. I hereby grant permission for non-prescription medication (such as non-aspirin products, i.e. acetaminophen or ibuprofen, benedryl, throat lozenges, cough syrup) to be given to my child, if deemed appropriate.
Signature: _____ Date: _____

3c. 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.
Signature: _____ Date: _____

4. Specific Medical Information: The parish will take reasonable care to see that the following information will be held in confidence:

Allergic reactions (medications, foods, plants, insects, etc.):_____
Immunizations: Date of last tetanus/diphtheria immunization:_____
Does child have a medically prescribed diet? _____
Any physical limitations?_____
_____
You should be aware of these special medical conditions of my child:_____
_____

Signature: _____ Date: _____