

Permission Slip

TITLE OF POLICY: PARENTAL/LEGAL GUARDIAN PERMISSION FORM

POLICY NO. 5360

Revised 9/15/95

DIOCESE OF CHARLOTTE, NC

PARENTAL/LEGAL GUARDIAN PERMISSION FORM
FOR FIELD TRIP PARTICIPATION

Dear Parent or Legal Guardian:

Your son/daughter, guardianship is eligible to participate in a diocesan-sponsored activity that requires personal transportation to locations away from your home site. This activity will take place under the guidance and supervision of adult chaperones. A brief description of the activity follows:

ACTIVITY: Faithful Servant Catholic Leadership Institute, June 18 - 23, 2023. Belmont Abbey, Belmont, NC

DESIGNATED SUPERVISOR OR ACTIVITY: Paul Kotlowski and Katie Reyes

If you would like your child to participate in this event, please complete, sign and return the following statement of consent and release of liability. As parent, or legal guardian, you remain fully responsible for any legal responsibility which may result from any personal actions taken by the named child.

I hereby consent to participation by my child, _____ in the event described above. I understand that this event will take place away from parish grounds and that my child will be under the supervision of the designated supervisor on the stated dates. I further consent to the conditions stated above on participation in this event, including the method of transportation.

I give my permission for my child, in case of an emergency, to be taken to a physician or hospital by either the supervisor in charge or by an adult chaperone. I understand that every effort will be made to contact me. If I cannot be reached, however, I hereby give permission to the physician selected by the supervisor in charge or adult chaperone(s) to hospitalize and secure proper treatment (including surgery) for my son/daughter. The cost of any necessary medical care or treatment for my son/daughter will be my expense.

Parent's or Legal Guardian's Signature

Date

Phone number where you can be reached in case of emergency _____

Accident/Hospitalization Policy Name _____

Policy Number: _____ Email: _____

Health Form

(Completion required for final registration)

PLEASE RETURN FORM AT REGISTRATION:

NAME _____ DATE OF BIRTH _____
ADDRESS _____ FEMALE _____ MALE _____
_____ DIOCESE CHARLOTTE

Is this participant in general good health and able to participate in all normal activities?
YES _____ NO _____ (If not, please submit a statement indicating limitations.)

Please give date of most recent physical examination.

DATE: _____
FAMILY PHYSICIAN(S) OR CLINIC: _____
ADDRESS _____ PHONE _____

Immunization History GIVE DATES PLEASE:
DPT _____ DPT BOOSTER _____ TETANUS BOOSTER _____
POLIO SERIES _____ POLIO BOOSTER _____

Allergies (Please write yes or no next to each)
HAY FEVER _____ ASTHMA _____ SULFA _____
FAINTING _____ POISON IVY _____ OTHER _____
CONVULSIONS _____ PENICILLIN _____
BEE STING _____ OTHER _____

List Current Medications being taken and Current Medical Condition: _____

If any of the above are yes, please submit a statement of how the child has been treated and with what medication. Submit a statement of any other medications currently in use and what for. This and any other medication will be dispensed by the Director of the program.

Operations or Serious Injury _____
Dates _____

Please notify the office if this child is exposed to any communicable disease during the three weeks prior to program attendance.

In signing this application, I hereby certify that the above information is correct and give permission for my child to be transported in privately owned vehicles to and from public transportation or for approved out-of-program activities; and for the release of medical records to an attending physician in case of illness.
In case of medical emergency, I understand that every effort will be made to contact parents or guardian of participants. In the event that I cannot be reached, I hereby give permission to the physician selected by the Program Director to hospitalize, secure proper treatment for and to order injection, anesthesia or surgery for my child, as named herein.

SIGNATURE OF PARENT/GUARDIAN: _____ DATE _____
Telephone During Program: _____ Alternate Phone # _____
Family Health Insurance Co.: _____ Policy # _____