## 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 15 - 20, 2025. Valle Crucis Conference Center, Valle Crucis, NC

 DESIGNATED SUPERVISOR OR ACTIVITY: Paul Kotlowski and Denys Davis

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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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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 #\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Electronic Youth Activity Liability Waiver – Charlotte Diocese**

By submitting this electronic registration, as the child(ren)’s parent or guardian, I hereby grant permission form my child(ren) to participate in Faithful Servant Catholic Leadership Institute sponsored by the Office for Youth Ministry of the Diocese of Charlotte at the Valle Crucis Conference Center in Valle Crucis, NC, June 15-21, 2025.

THE SUBMITTER OF THIS REGISTRATION, BEING THE LEGAL PARENT OR GUARDIAN, ON BEHALF OF THEMSELVES, THEIR HEIRS, SUCCESSORS, AND ASSIGNS, AND ON BEHALF OF THE ABOVE-NAMED CHILD, THEIR HEIRS, SUCCESSORS, AND ASSIGNS, HEREBY AFFIRMATIVELY STATES AND AGREES AS FOLLOWS:

I hereby waive, release and agree to indemnify, hold harmless and defend the Roman Catholic Diocese of Charlotte, included but not limited to any and all associated institutions and/or entities, its/their officers, directors, employees, volunteers, coaches, representatives, participating individuals and agents (collectively referred to as the “Diocese”) from any and all claims arising from or in any way connected with the activity referred to herein, or in connection with any illness or injury (including death) and/or cost of medical treatment in connection therewith, without limitation. The above shall include reasonable attorney’s fees and expenses incurred by the Diocese in any action brought against them as a result of any such claim(s), without limitation.

I consent to the method of transportation and the conditions and supervision of said event and/or activity. As parent and/or legal guardian, I remain legally responsible for any personal actions taken by my minor child(ren). In case of an emergency, I give my permission for my child(ren) to be taken to a physician and/or hospital, by either the supervisor in charge, or by an adult authorized by the supervisor in charge, and to be administered any and all medication reasonably necessary for treatment. I understand that every reasonable effort will be made to contact me. If I cannot be reached, however, I hereby give permission to hospitalize and secure proper treatment (including surgery and medication) for my children). The cost of any medical care or treatment obtained for the benefit of the named child shall be my expense and not paid by the Diocese.

I, and on behalf of my family, heirs, and assigns, hereby grant to the Parish/School/Agency and/or The Roman Catholic Diocese of Charlotte herein referred to collectively as the “Diocese”, permission to record on photography film and/or video, whether digital or otherwise, pictures, images and/or reproductions of my child(ren)’s participation and/or my families participation in this activity. I agree that any or all of the material photographed may be used, in any form, as part of any future publications, brochure, social media, internet or other printed materials that the Diocese deems to be an appropriate use, and further that such use shall be without payment of fees, royalties, special credit or other compensation. I agree to indemnify and hold harmless the Diocese, its agents, representatives and assigns from any and all claims regarding the use of said material. Furthermore, I hereby waive any and all claims that I may have, or hereafter acquire, regarding the use of said material by the Diocese, its agents, representatives and assigns.

I understand that this waiver will remain in effect for the duration of said event and cannot be revoked unless in writing by me or my legal representative.