

School/Parish St. Andrew Catholic Church

School/Parish Year: 2010 through 2011

**LOCAL FIELD TRIP PERMISSION**

*This Permission must be returned to the Parish on the date established in the Local Field Trip Information or child will not be allowed to participate in the Field Trip. Failure to complete this Permission will necessitate that your child not participate in the Field Trip. No written notes or telephone calls will substitute for this Permission.*

I, the undersigned, am the custodial parent/legal guardian of \_\_\_\_\_ (Participant). I have received and reviewed the Local Field Trip Information provided by the Parish and agree to the terms, conditions, manner of transportation and costs contained therein and request that Participant be to allowed participate in the Local Field Trip to: \_\_\_\_\_ on \_\_\_\_\_ described therein.

**Emergency Medical Consent:** I hereby warrant that to the best of my knowledge, Participant is in good health and physically able to participate in the Local Field Trip and I assume all responsibility for the health and physical condition and ability of Participant to so participate. In the event of circumstances that indicate that Participant is in need of immediate medical care, I authorize and give permission for Participant to be transported to a hospital/clinic/medical facility for evaluation and emergency medical or surgical treatment, including any necessary X-ray examination. I authorize any licensed physician or medical center to treat Participant. **I accept full responsibility for any medical or hospital bills associated with the care of Participant.**

**Medication Consent:** My child requires medication during this Field Trip: \_\_\_\_ no \_\_\_\_ yes. If yes, the custodial parent must complete and return the **Medication Consent Form and Waiver** on the reverse side of this form prior to the Field Trip.

**Liability Waiver:** In consideration of the arrangement set forth herein, I do on behalf of myself, Participant and our respective heirs, successors, assigns and next of kin, release, waive, hold harmless, defend and covenant NOT TO SUE, St. Andrew Catholic Church (Parish/School Name), the Archbishop of the Archdiocese of Oklahoma City, and the Archdiocese of Oklahoma City and each of their respective departments, directors, administrators, teachers, officers, agents, representatives, volunteers and employees from any and all actions, claims, demands or liabilities, including without limitation, those for personal injuries or property damage, that I and/or Participant may suffer due to illness or injury suffered by Participant as a result of, or in connection with, participation in the Activity, including the administration of authorized medications, medical treatment and any consequences that may arise as the result of said treatment, including without limitation, travel to and from the Activity, housing, meals and collateral entertainment to the fullest extent permitted by law.

**Signature:**

Parent/Guardian Signature: \_\_\_\_\_ Date \_\_\_\_\_

Daytime Phone Number: \_\_\_\_\_ Cell Number: \_\_\_\_\_

I am willing to be a driver: (Please circle one) Yes No

My car has enough seat belts for \_\_\_\_\_ passengers. **If you are willing to be a driver please complete the Driver Information Form.**

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**MEDICATION CONSENT FORM AND WAIVER**

This form is to be used in conjunction with the first page of **Form B-2** *Local Field Trip Permission* and the **Form A** *Registration Consent and Waiver Form for RE/Youth Activities*. If a child requires medication during an extended on-site RE/Youth Activity or on a Field Trip, the custodial parent/guardian must complete this form and return to the Parish before the planned activity. Parents/guardians are responsible for reporting any changes in their child’s medical condition, including allergies to food, medicine, insects, etc. to the RE/Youth coordinator(s).

Medication Form for \_\_\_\_\_

REQUEST AND AUTHORIZATION TO ADMINISTER MEDICINES: I request and authorize the staff of the Activity to administer the medicines listed below to Participant, as indicated:

	<u>Name of Medicine</u>	<u>Dosage</u>
	<u>Frequency</u>	
1.	_____	
2.	_____	
3.	_____	
4.	_____	

**NOTE: ALL MEDICINES TO BE TAKEN OR ADMINISTERED MUST BE ARRANGED FOR IN ADVANCE AND MUST BE PROVIDED IN THEIR ORIGINAL PHARMACY CONTAINER, INCLUDING THE PARTICIPANT’S NAME AND DOCTOR’S INSTRUCTION.**

(Attach extra sheets if necessary)

I hereby **grant** \_\_\_\_ **do not grant** \_\_\_\_\_ permission for non-prescription medication (such as non-aspirin products, i.e., acetaminophen or ibuprofen, throat lozenges, etc) to be given to Participant, if deemed appropriate.

**SIGNATURE**

Parent/Guardian Name (please print): \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_