DEADLINE FOR RETURN: Wednesday, April 4, 2018

CATHOLIC MUTUAL GROUP

MEDICAL INFORMATION AND PARENTAL/GUARDIAN CONSENT FORM/LIABILITY WAIVER

Participant's name: _____
Date of birth: _____ Sex: _____
Parent/Guardian's name: _____
Home address: _____
Home phone: _____ Business phone: _____
I, _____ grant permission for my child, _____
Parent or guardian's name Child's name

to participate in this school event that requires transportation to a location away from the school site. This activity will take place under the guidance and direction of school/church employees and/or volunteers from Saint Rocco School/Church.

A brief description of the activity follows:

Date of event: **Tuesday, April 24. 2018**
Destination of event: **Providence Children's Museum**
Individuals in charge: **Mrs. Tavares and Mrs. Heaton**
Estimated time of Departure: **9:00am**
Estimated time of Return: **12:00pm**
Mode of transportation to and from event: **Bus**
Cost per **student** for the event: **$12.00**
Cost per **ADULT CHAPERONE** for the event: **$10.00**
(must have current BCI and Safe Environment)

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 Rocco School its officers, directors, employees and agents, and the Diocese of Providence, 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 school, its officers, directors and agents, and the Diocese of Providence, 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/school or the Diocese of Providence.

Signature: _____ Date: _____

OVER

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.)

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: _____

Other Medical Treatment: In the event it comes to the attention of the parish/school, its officers, directors and agents, and the Diocese of Providence, 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: _____

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: _____

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: _____

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

Specific Medical Information: The parish/school 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? _____
Does child have any physical limitations? _____

Is child subject to chronic homesickness, emotional reactions to new situations, sleep walking, bed wetting, fainting? _____
Has child recently been exposed to contagious disease or conditions, such as mumps, measles, chicken pox, etc.? If so, list date and disease or condition: _____
_____

You should be aware of these special medical conditions of my child: _____