MEDICAL INFORMATION AND PARENT/GUARDIAN CONSENT FORM/LIABILITY WAIVER

PART 1. GENERAL INFORMATION (please print)

Participant's Name:____ D.O.B: ________________
Parent/ Guardian's Full Name: ____
Home Address:_____________________________________City/Town:________________State:_______Zip:________
Home Phone:_______________________________ Business/Cell/Alternate Phone:_______________________________

I, ____________________________(parent/guardian's name) , grant permission for my child, ___________________________, to participate in this parish/school event will take place under the guidance and direction of parish/school employees and/or volunteers from _______________________________________(parish/school/agency).

A brief description of the program/activity is as follows:

Type of program/activity: Educational Field Trip- Humane Education Workshop at Mother of Hope Camp that will involve storytelling, presentation of how therapy dogs are trained and their role in helping people, interaction with a credentialed therapy dog, a guided sensory hike experience focusing on natural scents, & a related art activity.

Location of event: Mother of Hope Camp, 1589 Putnam Pike, Chepachet, RI 02814

Individual in charge: ____

Date of event: Monday, May 29, 2018 with RAIN DATE scheduled for Thursday, May 31, 2018

Time of departure from school: ___________ **Time of arrival back to school:** __________

Mode of transportation: _________________ **Student Cost:** _________________________

As a 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 Mother of Hope Camp, the Catholic Youth Organization of the Diocese of Providence, the Roman Catholic Bishop of Providence, its employees and agents, (parish/school/agency)____________________________________, its employees and agents, chaperons, or representatives associated with the event from any claim arising from or in connection with my child participating in 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 Mother of Hope camp, the Catholic Youth Organization of the Diocese of Providence, the Roman Catholic Bishop of Providence, its officers, director, and agents, (parish/school/agency)____, its officers, directors, and officers, director, and agents, chaperons, or representatives associated with the events 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 Mother of Hope Camp, the Catholic Youth Organization of the Diocese of Providence, the Roman Catholic Bishop of Providence, or (parish/school/agency)____.

I AUTHORIZE Mother of Hope Camp to use photographs/videos of my child/ward for productions publications, promotion of Mother of Hope Camp and/or therapy pet programs (when applicable), etc. ☐ Yes ☐ No

Please check one of the following:

☐ My child may fully participate in the program.

☐ My child may participate in the program/activity with the following restrictions: ______________________________________

Parent/Guardian Signature: ____ Date: ______________________________

Parent/Guardian Name (Printed): ____ Contact Ph. #: _______________________

PART 2. 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:
Print Parent/Guardian Name: ____
Emergency Phone: ______________________ Family Doctor: ______________________________ Phone: _________________
Family Health Plan Carrier: ____Policy #: _______________________________

If parent/guardian cannot be reached, please contact: ________________________ Phone: ____________ Relationship: _________
Parent/Guardian Signature: ____ **Date:** ______________

Other Medical Treatment: In the event that it comes to the attention of Mother of Hope Camp, the Catholic Youth Organization of the Diocese of Providence, the Roman Catholic Bishop of Providence, its employees and agents, _____________________________(parish/school/agency), its employees and agents, chaperons, or representatives associated with the event, 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).
Parent/Guardian Signature: ____ **Date:** _______________

MEDICATIONS: CHECK AND SIGN ALL THAT APPLY:
___ My child is taking medication at present. My child will bring all such medications necessary and such medications will include pharmaceutical labeling including the child's name, prescription information, dosage, and frequency. Names of medications and concise directions for seeing that my child takes such medications, including dosage and frequency of dosage are as follows:
____
Parent/Guardian Signature: ____ **Date:** _______________

___ No medication of any type, whether prescription or non-prescription, may be administered to my child unless the situation if life-threatening and emergency treatment is required.
Parent/Guardian Signature: ____ **Date:** _______________

___ I hereby grant permission for non-prescription medication to be given to my child if deemed appropriate.
Please check the following non-prescription medication , which SHOULD NOT be administered:
___ acetaminophen (Tylenol) ___ ibuprofen (Advil, Motrin)
___diphenhydramine antihistamine/allergy medicine (Benadryl) ___ topical antihistamine/allergy medicine
Parent/Guardian Signature: ____ **Date:** _______________

SPECIFIC MEDICAL INFORMATION: The parish/school/agency will take reasonable care to see that the following information will be held in confidence.

Allergies (medications, food, animals, plants, insects, etc): ____
Reaction: ____
Treatment: ____

Date of last tetanus/diphtheria immunization: ____

Physical limitations: ___ No ___ Yes: ____

Other conditions that might affect your child's safe participation in this program: ____
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