

GENERAL PERMISSION/AUTHORIZATION FOR HARVEST SATURDAY-SIGNIFICANT INFO

**St. Andrew the Apostle Church
505 Kingston, Romeoville, IL 60446**

Must be returned ON Saturday, November 23, 2024..... Children must be 5th grade through 12th grade

I, _____, request that my child _____ be allowed to participate as a
PRINT PARENT NAME PRINT CHILD'S NAME

volunteer for the **Harvest Saturday Food Drive** on **November 23, 2024**. I hereby release and indemnify St. Andrew the Apostle Church, it's staff and volunteers, and the Diocese of Joliet, from any and all liability arising from any claims of any kind or nature whatsoever from my child's participation in this event.

This means children will be assigned tasks at the St. Andrew drop off site only.

Please dress appropriately for the weather, as some will be working outside collecting food from the vehicles driving up to the building.

Medical Permission

I grant permission for the **administration of first aid** to _____:

Name of Child

- **By the people in charge of Harvest Saturday**, and those transporting my child to and from the program as their judgment deems advisable, and to make the necessary referrals to qualified physicians for treatment of illness or accidents of a more serious nature.
- **I understand I will be promptly notified** in the event of any serious illness or accident and prior to any major surgery, except when delay in such communication would endanger life.
- In case of **medical emergency**, **I understand** that every effort will be made to **contact the parent/guardian** of the participant first before taking any further action.
- In the **event that I cannot be reached**, **I hereby give permission to the physicians selected** by the adult staff to hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery, if deemed necessary for the child.

Student Signature: I, _____, understand that I will need to follow the directions, expected guidelines, and proper/respectful behaviors for this event at all times.

Student's Birth Date ____/____/____ Student Cell Phone Number (____) _____ - _____

Allergies: To Medication? To food? Other? No____ Yes____
If YES, please list and describe. _____

List Medication(s) presently taking: _____

Insurance Information: "I understand that I or my insurance company will be responsible for any costs incurred."

Policy in the name of: _____ Policy Number: _____

Insurance Company: _____ Identification Number _____

Authorized Physician: _____ Phone Number(____) _____ - _____

Signature of Parent/Guardian: _____ **Date:** ____/____/____

Address: _____

Street City
Phone Number (____) _____ - _____ Parent Cell Phone Number (____) _____ - _____

CIRCLE YOUR ORGANIZATION:

CHURCHES:	ST. ANDREW	THE ROCK	COMMUNITY CHRISTIAN	UNITED PRESBYTARIAN
ST. ANDREW:	SCHOOL	CONFIRMATION	RELIGIOUS ED	
ROMEOVILLE HS:	ROTC	NHS	STUDENT GOV.	
MIDDLE SCHOOL:	A. VITO MARTINEZ	JANE ADDAMS	JOHN. J. LUKANCIC	HUBERT H. HUMPHREY
ORGANIZATIONS:	GIRL SCOUTS	BOY SCOUTS	FED-EX HOME DEPOT	OTHER _____

*** I WILL NEED A NOTE OF PROOF FOR MY SERVICE HOURS YES OR NO**

You could also email _____ at _____
Person email address