PARENTAL FIELD TRIP AND TRANSPORTATION NOTIFICATION, LIABILITY WAIVER, AND MEDICAL INFORMATION FORM.

We, the parent or guardian of ____
(Child's name)

permit our son/daughter to attend the _____________________________________
(name of trip/destination)

being planned by ___________________________ on ________________________
(parish representative) (date)

from __________________ to _____________________. The purpose of this trip is:

____

We, as parents/guardians of the undersigned minor(s), hereby consent and agree to hold harmless, _________________________ Parish and/or the Roman Catholic Diocese of Lafayette-in-Indiana, Inc., and any and all employees or volunteers thereof, for any accident, injury or occurrence arising out of, or in connection with the activity and our child ('s) event arranged transportation necessary to participate in the aforementioned activity. We understand that our child/ren will be assigned to ride with a licensed adult driver, driving a privately-owned automobile, or school bus and that this assignment will be made by the aforementioned teacher/faculty advisor.

I give my permission for my son/daughter, in case of an emergency, to be taken to a physician or hospital by either a parent in charge or by parish personnel. I understand that every effort will be made to contact me. If I cannot be reached, I hereby give permission to the physician selected by the parish member in charge or adult chaperon(s) to secure proper treatment for my son/daughter.

Parish Representative Signature: ___________________________ Date: __________

Child Signature: ____ Date: __________

Parent/Guardian Signature: ________________________________ Date: __________

Parent/Guardian Signature: ________________________________ Date: __________

Accident/Hospitalization Policy Name: _______________________________________

Policy Number: _________________________

PLEASE NOTE THAT PARENT (S)/GUARDIAN (S) MUST COMPLETE, SIGN AND DATE THIS AND THE MEDICAL INFORMATION ON THE OTHER SIDE.

MEDICAL MATTERS: I hereby warrant that to the best of my knowledge, my child is in good health, and I assume all responsibilities for the health of my child. Of the following statements pertaining to medical matters, **sign only those in accordance with your wishes.**

Emergency Medical Treatment: In the event of an emergency, I hereby give permission to Parish, it's officers, directors and agents, and Diocese of Lafayette-in-Indiana, agents, representatives, volunteers and employees of either the diocese or any parish thereof, and chaperones or representatives associated with this event 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 and RELATIONSHIP: ____

Telephone: (___)____

FAMILY DOCTOR: ____

Telephone: ( )____

FAMILY HEALTH PLAN CARRIER____

Policy Number: ____

(1) Signature: ____ Date: _______________

Other Medical Treatment: In the event it comes to the attention of the parish, its officers, directors and agents, and the Diocese of Lafayette-in-Indiana and all parishes within the diocese, and the officers, agents representatives, volunteers and employees of either the diocese or any parish thereof, and chaperones 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 telephone charges reversed to myself).

(2) 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: ___________________________________
____

(3) 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.

(4) Signature: ____ Date: ______________________

I hereby grant permission for non-prescription medication (such as aspirin, throat lozenges, cough syrup) to be given to my child, if deemed advisable.

(5) Signature: ____ Date: ______________________

Specific Medical Information: Parish will take the 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:__________________________________
____
- Medications child currently takes: ____
____
- Does child have a medically prescribed diet?____
____
- Any physical limitations?____
- Is child subject to chronic homesickness, emotional reactions to new situations, sleepwalking, bedwetting, fainting?
____
- Has child recently been exposed to contagious disease or condition, such as mumps, measles, chicken pox, etc.? If so, date and disease or condition:____
____
- You should also be aware of these special medical conditions of my child:___________________________
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