DFR 09/2019

FIELD TRIP

Participant's name: _____
Birth date:_____Sex:_____
Parent/Guardian's name: _____
Home address: _____
Home phone_____Cell_____Business_____

I, _____grant permission for this participant,_____
Parent or guardian's name
to participate in this event that requires transportation to a location away from the parish/school site. This activity will take place under the guidance and direction of parish/school employees and/or volunteers from Holy Name School
Name of parish/school

A brief description of the activity follows:
Type of event: _____
Destination of event: _____
Individual in charge:_____
Estimated time of departure and return: _____
Mode of transportation to and from event: _____

As parent and/or legal guardian, I remain legally responsible for any personal actions taken by the above named participant.

I agree on behalf of myself, this participant named herein, or our heirs, successors, and assigns, to hold harmless and defend _____, the
Name of parish/school
Roman Catholic Bishop of Fall River, Corp Sole, its officers, directors, employees and agents, chaperones, or representatives associated with the event, from any claim arising from or in connection with this participant 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 parish/school, the Roman Catholic Bishop of Fall River, Corp Sole, its officers, directors, employees and agents, chaperones, or representatives 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.

Print Name: _____

Signature: _____ Date: _____

COMPLETE REVERSE SIDE IN FULL

MEDICAL MATTERS: I hereby warrant that to the best of my knowledge, this participant is in good health, and I assume all responsibility for the health of this participant.

Medical Treatment: In the event that this participant becomes ill with symptoms such as headache, vomiting, sore throat, fever, diarrhea, I want to be contacted at the following phone numbers:
1_____ 2_____ 3 _____

Emergency Medical Treatment: In the event of an emergency, I hereby give permission to transport this participant to a hospital for emergency medical or surgical treatment. I wish to be advised by the hospital or doctor prior to any further treatment. In the event of an emergency, if you are unable to reach me at the provided numbers, contact:

Name & Relationship: _____ Phone_____
Family Doctor: _____ Phone: _____
Family Health Plan Carrier: _____ Policy #: _____

Signature: _____ Date: _____

Medications: This participant is taking medication at present. The parent/guardian will ensure medications are well-labeled and will bring such medications and present them to the parish/school. Names of medications and concise directions including dosage and frequency of dosage, are as follows _____

Please note: The medication may be administered by someone other than the school nurse, who will be a qualified designee Please sign below to provide your consent

Signature: _____Date: _____

Non-Prescription medication: of any type, (i.e. non-aspirin products such as ibuprofen or acetaminophen, throat lozenges, cough syrup):
CHOOSE ONE: ○ **may** ○ **may not** be administered to this participant
○ contact me at the #'s provided before administering
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.): _____
Date of last tetanus/diphtheria immunization _____
Does this participant have a medically prescribed diet?_____
Any physical limitations?_____
Is this participant subject to homesickness, emotional reactions to new situations, anxiety? _____

Has this participant 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 this participant:
_____