

**2018-2019  
GENERAL PERMISSION SLIP**



**Form  
6153(b)**

STUDENT NAME AND GRADE in Fall		STUDENT BIRTHDATE		CIRCLE: Male                      Female	
NAME OF PARENT/GUARDIAN		PHONE:		NAME OF PARENT/GUARDIAN	
				PHONE:	
FAMILY PRIMARY ADDRESS			PRIMARY EMAIL ADDRESS		

**TRIP INFORMATION TO BE FILLED IN BY OFFICE PRIOR TO EVENT**

PARISH/SCHOOL:		EVENT DATE(S): <b>TBD</b>	
DESIGNATED TEACHER/SUPERVISOR:		PHONE:	
DESTINATION:			
ACTIVITIES: (A SEPARATE DETAILED ITINERARY AND PARENT CONSENT MUST BE PROVIDED FOR HIGH RISK ACTIVITIES.)			
MODE OF TRANSPORTATION TO AND FROM EVENT:			
DAILY START TIME:		DAILY END TIME:	
STUDENT COST (IF APPLICABLE):		RETURN FORM BY: <b>NA</b>	
ITEMS STUDENTS SHOULD BRING (IF ANY):			

**Parent Consent to Participate and Indemnity Agreement:**

In consideration for my child/ward's participation, I agree to reimburse and indemnify the parish/school for all reasonable legal and court fees incurred by parish/school in defending a lawsuit that I or my child/ward may bring against the parish/school which relates to the above named activity if the parish/school is found not legally liable by the courts and prevails in the lawsuit. If the parish/school is found legally liable for injuries sustained by child/ward, this paragraph will not apply.

I certify that I have an understanding of this agreement and any risks and hazards associated with the activity described above that my child/ward will be participating in. I further understand that I had the opportunity to fully discuss this agreement with a representative of the parish/school to clarify any concerns or questions about the activity or this agreement that I may have had.

I have read the information above and give consent for my child to participate in all aspects of this field trip:

[Photo Consent and Video Release](#)

I, \_\_\_\_\_, consent to the use by the Archdiocese of Milwaukee and St. Mary parish, in Kenosha any videotape, photograph, slide, audiotape, or any other visual or audio reproduction in which I or my child may appear. I understand that these materials are being used for promotion of Office for Schools, Child and Youth Ministry or the above named parish/school. Such promotional activities extend to recruitment, fund-raising, advocacy, etc. I release the staff, volunteers, etc. of the Archdiocese of Milwaukee or the above named parish/school from any liability connected with the use of my or my child's picture or voice recording as part of any of the above or similar activities.

**My child may be pick up by the following individual(s):**

<b>NAME</b>	<b>RELATION TO CHILD</b>	<b>PHONE NUMBERS</b>
1.		
2.		
3.		

PARENT/GUARDIAN SIGNATURE:	DATE:      This form is valid for one year after date below
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**Emergency Medical Treatment:** In the event of an emergency, I give permission to transport my child to a hospital for emergency medical treatment. I wish to be advised prior to any further treatment by the hospital or doctor.

If you are unable to reach a parent/guardian at the above numbers, contact:

ALTERNATE CONTACT NAME:	PHONE:
PHYSICIAN'S NAME:	PHONE:
NAME OF MEDICAL INSURANCE:	POLICY #:
PERTINENT MEDICAL CONDITIONS, INCLUDING ALLERGIES AND SPECIAL DIETARY NEEDS:	

**Other Medical Treatment:** In the event that the child becomes ill with symptoms such as headache, vomiting, sore throat, fever, or diarrhea, do you grant permission for supervisors to give your child non-prescription medication, such as acetaminophen, throat lozenges, cough syrup, or antacid?

Yes  No, I wish to be contacted first.

**Medications:** List all medications, prescription and over-the-counter, that the student currently takes at home and during the school day. Include all as-needed (such as ibuprofen) and emergency medications. Medications not authorized for self-carry must be in original container and given to the designated supervisor.

MEDICATION:	DOSAGE:	ROUTE: HOW GIVEN:	FREQUENCY:	START DATE:	STOP DATE:	SIDE EFFECTS:
1.						
2.						
3.						

**MEDICAL PROVIDER CONSENT:** REQUIRED FOR PRESCRIPTION MEDICATIONS LISTED ABOVE.

<b>I Authorize the School/Parish to Give the Above Prescription Medication(S) to this Student.</b>	
PRINT MEDICAL PROVIDER NAME:	PHONE:
MEDICAL PROVIDER SIGNATURE:	DATE:
<b>Inhaler and Epi-Pen Only:</b> This student and his/her parents have been instructed in self-administration and the student may carry an inhaler or Epi-Pen and self-administer. Yes <input type="checkbox"/> No <input type="checkbox"/>	

**PARENT CONSENT FOR MEDICAL TREATMENT AND ADMINISTRATION OF MEDICATION**

<b>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. I give the school/parish permission for emergency and other medical treatment, including the administration of the above prescription and non-prescription medication(s).</b>	
PARENT/GUARDIAN SIGNATURE:	DATE:
<b>Inhaler/Epi-Pen Only:</b> My child may <input type="checkbox"/> or may not <input type="checkbox"/> carry and self-administer. CHILD'S NAME _____	