

**PARENT/LEGAL GUARDIAN PERMISSION SLIP  
AND INDEMNITY AGREEMENT**

11/7/06

Your son/daughter, ward, \_\_\_\_\_ is eligible to participate in a school/parish sponsored activity that requires permission. This activity will take place under the guidance and supervision of employees/volunteers from St. Benedict Parish/Totus Tuus.

A brief description of the activity is as follows:

TYPE OF ACTIVITY: Totus Tuus at St. Benedict's

DESCRIPTION OF ACTIVITY: Catholic Day Camp

DATE AND TIME OF ACTIVITY: July 8 – 13, 2018 (9am – 2:30pm or 7 – 9pm)

METHOD OF TRANSPORTATION (IF APPLICABLE): n/a

STUDENT COST (IF APPLICABLE): Grades 1-6: \$30; Grades 7-12: \$15 (\$60 max per family)

I consent to the participation of my child/ward in the above named activity. In consideration for my child/ward's participation, I agree to reimburse and indemnify the above named parish/school (understood to include the Diocese of Duluth) 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 liable for the injuries sustained by child/ward, this paragraph will not apply.

I certify that I have an understanding of this agreement and the 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.

\_\_\_\_\_  
Parent/Legal Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Address

\_\_\_\_\_  
Home Phone

\_\_\_\_\_  
Work Phone

**EMERGENCY MEDICAL TREATMENT:** In the event of an emergency, I give permission to transport my child/ward to a hospital for emergency medical 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

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Medical Insurance Company

\_\_\_\_\_  
Policy Number

Please furnish medical information about your child/ward which may be pertinent to his or her participation in the above identified activity: \_\_\_\_\_

**PLEASE RETURN TO: Parish Office**

**BY: July 8th**

Please keep this form on file at the parish or school for six (6) years.

I-40