Due Oct 30th, 2019 (LIMITED TICKETS!)

The Church of Saint Henry

Lifeline – November 2nd, 2019

PARENTAL CONSENT FORM & INDEMNITY AGREEMENT

Youth Participant Name: _____

Date of Birth: ___/___/___ Grade: 8th / 9th / 10th / 11th / 12th School: _____

Parent/Guardian Name: _____ *Willing to chaperone?* Yes / No

Home Address: _____

Parent E-mail Address: _____

Parent Primary Phone:_____ Parent Secondary Phone: _____

Date of Event: **Saturday, November 2nd, 2019**
Type of Field Trip: **Lifeline**
Destination: **Chick-Fil-A** (1770 Robert St S, West Saint Paul, MN 55118) and **NET Ministries** (110 Crusader Ave West, West Saint Paul, MN 55118)
Student Cost: **$20 (ticket and bus) and spending money for dinner**
Individual in Charge: **Jenna Leighton (Director of Youth Formation and Ministry)**
Departure Time: **2:30pm** Return Time: **11pm**
Drop-off/Pick-up Location**: The Church of Saint Henry**
Mode of Transportation To & From Event: **Bus**

I, _____, grant permission for _____
Parent/Guardian Name Child Name
to participate in the above named activity and I warrant that my child is in good health. In consideration of my child's participation, I agree to indemnify the Church of Saint Henry and the Archdiocese of Saint Paul and Minneapolis from any claims or law suits brought against the Church of Saint Henry /Archdiocese of Saint Paul and Minneapolis by myself, my child or others, that arises out of any behavior by my child at the event/activity described above. I also agree to pay reasonable attorney's fees or expenses incurred by the parish/school and the Archdiocese in defense of such a claim/suit.

EMERGENCY MEDICAL TREATMENT: In the event of an emergency, I give permission to transport my child to a hospital for medical treatment. I wish to be advised prior to any further treatment by a doctor or hospital. In the event of any emergency, if you are unable to reach me at the above numbers, contact _____ at _____.
Emergency Contact Name Emergency Contact Phone Number

MEDICAL INFORMATION:
Allergies, dietary restrictions, or any conditions we should be aware of: _____

_____

Family Health Plan carrier number: _____

Family Doctor: _____ Phone Number: _____

As Parent or Guardian, I agree to all of the above stated considerations and conditions.

_____ _____
Signature **Date**