SAN CLEMENTE PARISH RELIGIOUS EDUCATION

PARENT / GUARDIAN
PERMISSION SLIP/MEDICAL AUTHORIZATION / INDEMNITY AGREEMENT

SPONSOR OF ACTIVITY San Clemente Church

ACTIVITY Confirmation Year II Retreat

DATE(S) OF ACTIVITY Friday, March 1, 2019- Sunday March 3, 2019

PLACE OF ACTIVITY Madonna Retreat Center, Albuquerque

As parent and/or legal guardian of: _____
FIRST NAME **LAST NAME**

I remain legally responsible for any personal actions taken by the above named minor ("participant").

I agree on behalf of myself, my child named herein, or our heirs, successors, and assigns, to hold harmless and defend

San Clemente Parish, Religious Education

its officers, directors, employees and agents, and the Archdiocese of Santa Fe, its employees and agents, chaperones, or representatives associated with the event, from any claim arising from or in connection with my child 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, its officers, directors and agents, and the Archdiocese of Santa Fe, its employees and agents and chaperones, or representative 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 or the Archdiocese of Santa Fe.

I hereby authorize the Supervisor of the activity or his/her designee to act in my behalf to authorize such medical attention, surgery, or other health care services, as may be recommended in an emergency situation while participating in the activity. If the below named physician cannot be reached, I hereby authorize any licensed physician or medical center to treat my child.

I hereby authorize the Supervisor of the activity or his/her designee to administer the following medication to my child according to the instructions described here:

Medication: _____

Directions: _____

If the medication is prescribed by a doctor, the prescription in its original container will be provided to the Supervisor of the activity.

Name of Physician _____ Phone: _____

Signature: _____ Date: _____
Parent/Guardian

Print Name: _____

Phone: _____ Phone: _____
Home Work

Revised 3/02/10