



### PARENT/GUARDIAN PERMISSION SLIP FOR EXTENDED DAY/OVERNIGHT FIELD TRIP

NAME OF STUDENT:	
NAME OF PARENT/GUARDIAN:	PHONE:
NAME OF PARENT/GUARDIAN:	PHONE:

#### TRIP INFORMATION:

PARISH/SCHOOL:	DATE(S) OF TRIP:
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:	
DEPARTURE DATE/TIME:	RETURN DATE/TIME:
STUDENT COST (IF APPLICABLE):	RETURN FORM BY:
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:

PARENT/GUARDIAN SIGNATURE:	DATE:

By entering my full name, I attest that this constitutes my legal electronic signature on this form.

~~Yes, I am available to chaperone. I can be reached at:~~

Check the box if you opt out of any image, photograph, or video of your child to be posted or published to social media by any chaperone or school personnel for this field trip.

**PAGE TWO: EXTENDED DAY/OVERNIGHT FIELD TRIP MEDICAL RELEASE:**

**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 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**

I authorize the School/Parish to Give the Above Prescription Medication(S) to this Student.

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:**

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).	
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.	

By entering my full name, I attest that this constitutes my legal electronic signature on this form.

**PAGE 3: HIGH-RISK ACTIVITY ADDENDUM TO PARENT PERMISSION SLIP:**

<b>PARISH/SCHOOL:</b>	<b>DATE(S) OF ACTIVITY:</b>
<b>NATURE OF EVENT OR ACTIVITY (i.e., retreat, field trip, mission trip):</b>	
<b>DESTINATION/VENUE:</b>	
<b>DESTINATION/VENUE'S WEBSITE:</b>	

**IMPORTANT NOTE TO PARENTS:**

This event offers activities that are considered high-risk to participants. Parish/school staff and volunteers are not qualified to provide instruction or supervision for these high-risk activities; however, the destination/venue has trained staff who will be in charge of these activities.

Listed below are high-risk activities that are available to your child. Please indicate your approval or disapproval next to each activity. Students will be given an alternate low-risk activity in which to participate if the parent does not want the child to participate in a high-risk activity. In addition to this document, the destination/venue may have a separate liability waiver that you will need to sign in order for your child to participate in the activity. The venue's website is provided above for additional information. Please communicate with the parish/school staff if you have concerns with your child participating in a particular activity.

ACTIVITY: TO BE LISTED BY PARISH/SCHOOL	PARENT INITIALS:	
	APPROVED	NOT APPROVED

<b>PARENT/GUARDIAN SIGNATURE:</b>	<b>DATE:</b>
<b>STUDENT'S NAME:</b>	

By entering my full name, I attest that this constitutes my legal electronic signature on this form.