

# PARENTAL CONSENT/MEDICAL RELEASE FORM

NAME \_\_\_\_\_ AGE \_\_\_\_\_ BIRTHDATE \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_

PHONE \_\_\_\_\_ SCHOOL \_\_\_\_\_ GRADE \_\_\_\_\_ CHURCH \_\_\_\_\_

PARENT (S)/GUARDIANS BUSINESS PHONE \_\_\_\_\_

**EMERGENCY CONTACT (OTHER THAN PARENT/GUARDIAN)** \_\_\_\_\_

To Whom It May Concern:

The undersigned does hereby give permission for \_\_\_\_\_ (Child's Name) to participate in the following activity sponsored by St. Francis de Sales.

ACTIVITY: High School Spring Retreat @ Camp Geneva, in Holland, MI

DATE & TIME: Friday March 16 – Sunday March 18, 2018

TRANSPORTATION: **Parent Drop off @ Camp Geneva 3995 Lakeshore Dr, Holland, MI on Friday @ 6:15 pm and pick-up on Sunday @ 12:15 pm.**

COST: **\$150.00** Note: \$100 scholarship available on a limited basis. If you are interested in the scholarship check the box.  **St. Francis office will contact you to confirm.**

DESIGNATED SUPERVISORS: **Ricardo Valdez**

Coordinators: **Ricardo Valdez: cell Phone # 240-285-9373**

In consideration of my child being allowed to participate in this Youth Activity, I hereby agree on behalf of myself and my child, to release **St. Francis de Sales**, the Roman Catholic diocese of Grand Rapids, and any and all affiliated organizations, their employees, agents and representatives, including volunteer drivers, from any and all claims, including negligence, which may be asserted by me or my child, or on behalf on my child, arising from or relating to my child's participation in the field trip.

In consideration of my child being allowed to participate in this Youth Activity, I hereby agree on behalf of myself and my child, to release St. Francis de Sales, the Roman Catholic (Arch) diocese of Grand Rapids, and any and all affiliated organizations, their employees, agents and representatives, including volunteer drivers (collectively "Releasees"), from any and all claims, including negligence, which may be asserted by me or my child, or on behalf on my child, arising from or relating to my child's participation in the field trip.

We(I) authorize an adult, in whose care the minor has been entrusted, to consent to any X-ray examination, anesthetic, medical, surgical, or dental diagnosis or treatment, and hospital care, to be rendered to the minor under the general or special supervision and on the advice of any licensed physician or licensed dentist on the medical staff of a licensed hospital, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital.

The undersigned shall be liable and agree(s) to pay all costs and expenses incurred in connection with such medical and dental services rendered to the aforementioned child pursuant to this authorization.

Should it be necessary for our (my) child to return home due to medical reasons or otherwise, the undersigned shall assume responsibility for transportation and/or incurred transportation costs.

Insurance Company \_\_\_\_\_ Policy Number \_\_\_\_\_

Participant Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent(s)/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Below please list any allergies or special medical problems you child may have. Thank you.

\_\_\_\_\_

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