ARCHDIOCESE of MILWAUKEE

Form
6153(b)

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: St. Mary's Visitation Parish 2023 Confirmation Retreat	DATE(S) OF TRIP: January 28, 2023
DESIGNATED TEACHER/SUPERVISOR: Erica Nelson	PHONE: 414-313-5235 (cell)
DESTINATION: St. Benedict Abbey	
ACTIVITIES: (A SEPARATE DETAILED ITINERARY AND PARENT CONSENT MUST BE PROVIDED FOR HIGH RISK ACTIVITIES.) Confirmation Retreat	
MODE OF TRANSPORTATION TO AND FROM EVENT: Bus from SMV to retreat center and back- parents to drop off and pick up teens from SMV	
DEPARTURE DATE/TIME: Saturday, January 28, 2023 - 8:00 AM	RETURN DATE/TIME: Saturday, January 28, 2023 - 3:30 PM
STUDENT COST (IF APPLICABLE): covered by registration fee	RETURN FORM BY: December 1, 2022
ITEMS STUDENTS SHOULD BRING (IF ANY): prayer book/bible/rosary/journal	

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:
☐ YES, I AM AVAILABLE TO CHAPERONE. I CAN BE REACHED AT	

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:
Inhaler and Epi-Pen Only: 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 ☐ No ☐	

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:
Inhaler/Epi-Pen Only: My child may ☐ or may **not** ☐ carry and self-administer.	