

DATE: \_\_\_\_\_

Appendix #36

**PARENTAL FIELD TRIP AND TRANSPORTATION NOTIFICATION, LIABILITY WAIVER,  
AND MEDICAL INFORMATION FORM.**

We, the parent or guardian of \_\_\_\_\_  
(Child's name)

Permit our son/daughter to attend the Life Teen Away for a Day Retreat at St. Mary's in the Woods  
(Name of trip/destination)

Being planned by Kristi Powers on November 6, 2021  
(Parish representative) (Date)

From 8:30am to 8:30pm.

The purpose of this trip is: To help teens step away from the stress in their lives to encounter Christ and learn more about our call to holiness through the life of St. Mother Theodore Guerin

We, as parents/guardians of the undersigned minor(s), hereby consent and agree to hold harmless, \_\_\_\_\_ parish and/or the Roman Catholic Diocese of Lafayette-in-Indiana, Inc., and any and all employees or volunteers thereof, for any accident, injury or occurrence arising out of, or in connection with the activity and our child's event arranged transportation necessary to participate in the aforementioned activity. We understand that our child will be assigned to ride with a licensed adult driver, driving a privately owned automobile, or bus and that this assignment will be made by the aforementioned DRE/YM.

We give our permission for our son/daughter, in case of emergency, to be taken to a physician or hospital by either a parent in charge or by parish personnel. We understand that every effort will be made to contact us. If we cannot be reached, we hereby give permission to the physician selected by the parish member in charge or adult chaperone(s) to secure proper treatment for our son/daughter.

Parish representative signature \_\_\_\_\_ Date \_\_\_\_\_

Child signature \_\_\_\_\_ Date \_\_\_\_\_

Parent/guardian signature \_\_\_\_\_ Date \_\_\_\_\_

Parent/guardian signature \_\_\_\_\_ Date \_\_\_\_\_

Accident/hospitalization policy name \_\_\_\_\_

Policy number \_\_\_\_\_ Home phone/cell phone \_\_\_\_\_

**PLEASE NOTE THAT PARENT(S)/GUARDIAN(S) MUST COMPLETE, SIGN AND DATE THIS AND THE MEDICAL INFORMATION ON THE NEXT PAGE.**

**MEDICAL MATTERS:** I hereby warrant that to the best of my knowledge, my child is in good health, and I assume all responsibilities for the health of my child. Of the following statements pertaining to medical matters, **sign only those in accordance with your wishes.**

**EMERGENCY MEDICAL TREATMENT:** In the event of an emergency, I hereby give permission to the parish, its officers, directors and agents, and the Diocese of Lafayette-in-Indiana, agents, representatives, volunteers and employees of either the diocese or any parish thereof, and chaperones or representatives associated with this event to transport my child to a hospital for emergency medical or surgical treatment. I wish to be advised prior to any further treatment by the hospital or doctor. In the event of an emergency, if you are unable to reach me at the above number, contact:

NAME and RELATIONSHIP \_\_\_\_\_

Telephone number(s) \_\_\_\_\_

FAMILY DOCTOR \_\_\_\_\_

Telephone number \_\_\_\_\_

FAMILY HEALTH PLAN CARRIER \_\_\_\_\_

Policy number \_\_\_\_\_

(1) Signature \_\_\_\_\_ Date \_\_\_\_\_

**Other medical treatment:** In the event it comes to the attention of the parish, its officers, directors, and agents, and the Diocese of Lafayette-in-Indiana and all parishes within the diocese, and the officers, agents, representatives, volunteers and employees of either diocese or any parish thereof, and chaperones or representatives associated with the event, that my child becomes ill with symptoms such as headache, vomiting, sore throat, fever, diarrhea, I want to be called collect.

(2) Signature \_\_\_\_\_ Date \_\_\_\_\_

**Medications:** My child is taking medication at present. My child will bring all such medications necessary, and such medications will be labeled. Names of medications and concise directions for seeing that the child takes such medications, including dosage and frequency of dosage are as follows: \_\_\_\_\_

(3) Signature \_\_\_\_\_ Date \_\_\_\_\_

No medication of any type whether prescription or non-prescription may be administered to my child unless the situation is life threatening and emergency treatment is required.

(4) Signature \_\_\_\_\_ Date \_\_\_\_\_

I hereby grant permission for non-prescription medication (such as aspirin, throat lozenges, cough syrup) to be given to my child, if deemed advisable.

(5) Signature \_\_\_\_\_ Date \_\_\_\_\_

**Specific medical information: parish will take reasonable care to see that the following information will be held in confidence.**

Allergic reactions (medications, foods, plants, insects, etc.) \_\_\_\_\_

Immunizations: date of last tetanus/diphtheria immunization \_\_\_\_\_

Medications child currently takes \_\_\_\_\_

Does the child have a medically prescribed diet? \_\_\_\_\_

Does the child have any physical limitations? \_\_\_\_\_

Is the child subject to chronic homesickness, emotional reactions to new situations, sleepwalking, bedwetting, fainting? \_\_\_\_\_

Has the child recently been exposed to contagious disease or condition, such as mumps, measles, chicken pox, etc.? If so, date and disease or condition \_\_\_\_\_

You should also be aware of these special medical conditions of my child \_\_\_\_\_