

Archdiocese of Seattle

FIELD TRIP Parental/Guardian Consent Form and Liability Waiver

Participant's Name:	Date of Birth:
Parent/Guardian's Name:	
Home Address:	
Best Daytime Phone:	Cell Phone:
e-mail:	
I, (Parent/Guardian)	grant permission for my child, (Child's Name) , to participate in this organization-sponsored
	ay from the organization site. This activity will take place under the and/or volunteers from(Name of Organization)
A brief description of the activity follows:	(Name of Organization)
Type of event:	
Individual(s) in charge:	
Date and time of departure:	Return:
Mode of transportation to and from event:	
Cost:	
child is 4 feet 9 inches or taller. A child who is 8	rs olds must be restrained in child restraint systems, unless the 3 years old or older, or 4 feet 9 inches or taller, must be properly belt or an appropriately fitting child restraint system. Children seats where it is practical to do so.
As parent and/or legal guardian, I remain legally minor participant.	responsible for any personal actions taken by the above named
fend (Organization) Corporation of the Catholic Archbishop of Seattle any and all actions, claims, demands, damages, connection with my child attending the event or in connection therewith, and I agree to compensation	in, or our heirs, successors and assigns, to hold harmless and de, its officers, directors and agents, and the e, chaperones, or representatives associated with the event, from costs, expenses and all consequential damage arising from or in connection with any illness or injury or cost of medical treatment in ate the organization, its officers, directors and agents, and the e, chaperones, or representatives associated with the event for herewith.
Signature:	Date:

Participant's Name:	
Medical Matters:	
hereby warrant that to the best of my k the health of my child.	nowledge, my child is in good health, and I assume all responsibility fo
Emergency Medical Treatn	nent:
	give permission to transport my child to a hospital for emergency medied prior to any further treatment by the hospital or doctor. In the event h me at the above numbers, contact:
Name:	
Relationship:	Phone:
Family doctor:	Phone:
Family Health Plan Carrier:	Policy #:
nformation will be held in confidence: Allergic reactions (medications, foods, p	plants, insects, etc.):
	lants, insects, etc.):
lucus, inclinations alote of loot totomics/display	
Immunizations – date of last tetanus/dipl	ntheria immunization:
Does child have a medically prescribed	ntheria immunization:
Does child have a medically prescribed Any physical limitations?	ntheria immunization:diet?
Does child have a medically prescribed Any physical limitations? Is child subject to chronic homesickness bedwetting, fainting?	diet? diet? s, emotional reactions to new situations, sleepwalking, tagious disease or conditions, such as mumps, measles,
Does child have a medically prescribed Any physical limitations? Is child subject to chronic homesickness bedwetting, fainting? Has child recently been exposed to confidence in the confiden	diet? diet? s, emotional reactions to new situations, sleepwalking, tagious disease or conditions, such as mumps, measles, e or condition:
Does child have a medically prescribed Any physical limitations? Is child subject to chronic homesickness bedwetting, fainting? Has child recently been exposed to contachickenpox, etc.? If so, date and diseas	diet? diet? s, emotional reactions to new situations, sleepwalking, tagious disease or conditions, such as mumps, measles, e or condition:
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