



FIELD TRIP AUTHORIZATION & LIABILITY WAIVER FORM
(RETURN COMPLETED FORM TO PARISH/SCHOOL/AGENCY)

Name of Minor ("Participant"): _____
(PLEASE PRINT)

Home Address: _____ Email: _____

Primary Phone: _____ Secondary Phone: _____

Parent(s)/Guardian(s) Name(s): _____

I/we, _____
(Parent(s) Or Guardian(s) Name)

grant permission for my/our child, _____
(Participant's Name)

to participate in this Parish/School/Agency activity. This activity will take place under the employees and/or volunteers guidance and direction of

(Parish/School/Agency Name - Please Print)

A brief description of the activity follows:

Type of event: _____

Location(s): _____

Individual(s) in charge: _____

Dates of activity: _____

Mode of transportation to and from event: _____

As parent(s) and/or legal guardian(s), I/we remain legally responsible for any personal actions taken by the above-named Participant.

I understand and acknowledge that participation in the Field Trip involves inherent risks of injury to my child, including risks associated with transportation by motor vehicle. I acknowledge that this vehicle may be operated by a volunteer driver.

I authorize the Designated Supervisor(s) of the Field Trip to authorize and consent to any medical care for my child that he or she reasonably believes necessary, including, but not limited to, hospitalization or surgery. I agree to pay any expenses related to such medical care. I understand and acknowledge that the Designated Supervisor(s) of the Field Trip will attempt to obtain my permission by telephone before authorizing or consenting to any medical care for my child if time and conditions permit.

I understand and acknowledge that any medical expenses related to illness or injury to my child while on the Field Trip are not covered by any insurance program maintained by the Parish/School/Agency or the Diocese of Charlotte, and that I am primarily responsible for such expenses.

As parent and/or legal guardian, I remain legally responsible for any personal actions taken by the above-named minor (child).

I agree on behalf of myself, my child named herein, or our heirs, successors, and assigns, to hold harmless and defend the above-named Parish/School/Agency, its officers, directors and agents, chaperones, or representatives associated with the event, and the Diocese of Charlotte from any claims arising from or in connection with my child attending the event or in connection with any illness or injury or cost of medical treatment in connection therewith, and I agree to compensate the Parish/School/Agency, its officers, directors and agents, chaperones, or representatives associated with the event, and the Diocese of Charlotte for reasonable attorney's fees and expenses arising in connection therewith.

I hereby consent to my child's participation in the Field Trip. I have carefully read this Field Trip Authorization, and I understand and agree to each of the covenants and conditions set forth above.

Signature: _____
Parent or Guardian

Date: _____



MEDICAL MATTERS

The Parish/School/Agency will take all reasonable and prudent care to see that confidentiality regarding the following information is maintained.

I/We hereby warrant that to the best of my/our knowledge, my/our child is in good health, and I/we assume all responsibility for the health of my/our child. I/We understand and acknowledge that any medical expenses related to illness or injury to my/our child are not covered by any insurance program maintained by the Parish/School/Agency or the Diocese of Charlotte, and that I/we am/are responsible for such expenses.

Emergency Medical Treatment: In the event of an emergency, I/we hereby give permission to transport my/our child to a hospital for emergency medical or surgical treatment. I/we 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/us at the above numbers, please contact:

Name of Minor ("Participant"): _____

Sex: _____ Birth Date: _____

Name of Parent(s)/Guardian(s): _____

Emergency Phone(s): _____

Family doctor: _____ Phone: _____

Family Health Plan Carrier: _____

Policy #: _____

Allergic reactions (medications, foods, plants, insects, etc.): _____

Immunizations: Date of last tetanus/flu immunization: _____

Does Participant have a medically prescribed diet? _____

Any physical limitations? _____

Has Participant recently been exposed to contagious disease or conditions, such as mumps, measles, flu, chickenpox, etc.? If so, date and disease or condition:

Other special medical conditions: _____

Medications: Participant is taking medication at present.

Yes _____ No _____ If yes, list: _____

It is Participant's responsibility to bring all necessary medications in the original package/bottle with label and instructions.

Medications are to be administered by: My Child _____ Staff _____

NOTE: Parish/School/Agency staff and volunteers WILL NOT administer ANY medications requiring the use of a syringe or other needle delivery system. Alternate accommodations for must be made for these circumstances and the Parish/School/Agency fully informed of the nature of such accommodations.



ROMAN CATHOLIC DIOCESE OF CHARLOTTE

Office of Diocesan Properties & Risk Management

NOTICE: I want to be contacted in the event it comes to the attention of the Parish/School/Agency, its officers, directors and agents, and the Diocese of Charlotte, chaperones, or representatives associated with the activity that Participant experiences symptoms such as headache, vomiting, sore throat, fever, diarrhea, etc.

Yes _____ No _____

/We hereby grant permission for the following non-prescription medication (non-aspirin products such as acetaminophen or ibuprofen, throat lozenges, cough syrup, etc.) to be administered to the Participant, if deemed appropriate. (All medications supplied by the family must come in the original package/bottle with instructions and dosages.)

Yes _____ No _____

OR: 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.

Yes _____ No _____

Signature: _____
Parent Or Guardian

Date: _____