

**Cost = \$20.00
DUE SEPT. 19TH**

St. Richard Parish – “Crown of Creation” Womanhood Retreat

PARISH EVENT/TRIP PARENTAL PERMISSION & MEDICAL RELEASE FORM

Child's Name _____ Grade (Open to 9th, 10th, 11th) _____ Sex _____

Parishioner Non Parishioner, Friend of _____

Address _____ City _____ State _____ Zip _____ Home Phone _____

School _____ Grade _____ Birth Date _____ E-Mail _____

September 24-25, 2011 Saturday, 9:00 a.m. to Sunday, 1:30 p.m. Womanhood Retreat/St. Richard Church

Date(s) of Event _____ Time(s) of Event _____ Description/name of Event/Trip & Location(s) to be visited _____

Chaperones Needed: Can a parent chaperone or assist? No Yes – Parent Name _____

Is the parent “Safe Environments” Compliant? No Yes Not Sure

Permission for Child to Participate

I/we, the parent(s) or guardian(s) of the above mentioned child, give permission for my/our child to participate in the above mentioned event/trip on the above written date.

Medical Authorization

In the event of any injury or illness to my/our child during his/her participation in this program, I/we hereby give my/our permission for the necessary medical treatment to be given to my/our child. I/we agree that in case of injury to my/our child, we will apply my/our hospitalization and/or or accident insurance toward payment of the expenses incurred and will not look to St. Richard Parish or any other program sponsor or volunteer for the payment of any medical costs or injury related costs.

Parent/Guardian Signature(s) _____ Name(s) (Please Print) _____ Date _____

Phone number(s) for emergency _____

Insurance Company _____ Policy and/or ID number(s) _____

Name and phone number of person to call if parent is not available. _____

ATTENTION: PLEASE COMPLETE REVERSE SIDE ALSO!

St. Richard Parish – “Crown of Creation” Womanhood Retreat

PARISH EVENT/TRIP PARENTAL PERMISSION & MEDICAL RELEASE FORM

Cost = \$20.00
DUE SEPT. 19TH

Child's Name _____ Home Phone _____

CONSENT TO TREAT

I/We, the undersigned parent(s)/guardian of _____ (child's name), a minor, do hereby authorize treatment of my/our child by a licensed medical physician in case of any accident or illness that may so arise, or any hospitalization necessary. This medical consent will remain effective until **Sunday, September 25, 2011.**

Signature Father/Legal Guardian _____ Date _____ Phone(s) where you can be reached _____

Signature Mother/Legal Guardian _____ Date _____ Phone(s) where you can be reached _____

MEDICAL MATTERS: 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. *(Of the following statements pertaining to medical matters, sign only those in accordance with your wishes.)*

1) Medications: My child is **TAKING MEDICATION AT PRESENT.** My child will bring all such medications necessary, and such medications will be well labeled. My child will be responsible to administer his/her own medication.

Name of medication, time(s) to be administered, and dosage _____

Signature _____ Date _____

2) I hereby **grant PERMISSION FOR NON-PRESCRIPTION MEDICATION** (such as Tylenol, throat lozenges, cough syrup) to be given to my child if deemed advisable.

Signature _____ Date _____

3) **NO MEDICATING 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.

Signature _____ Date _____

Known allergies: _____

Known physical limitations: _____

Medically prescribed dietary needs: _____

Is child a vegetarian? No Yes

Is child subject to chronic homesickness, emotional reactions to new situations, sleepwalking, fainting? No Yes

Does child have any other special needs? No Yes – Please briefly describe _____

ATTENTION: PLEASE COMPLETE REVERSE SIDE ALSO!

Questions? Contact Hayley & Tim at (724) 444-1971 or hayleyd@saintrich.org & tim@saintrich.org