CATHOLIC MUTUAL "CARES" LOSS PREVENTION SYSTEM PARENT/GUARDIAN CONSENT FORM AND LIABILITY WAIVER

Curriculum Goal: **Chess Club**
Destination: **St. Vincent de Paul School Library**
Designated Supervisor of Activity**: National Master William Harrison**
Date and Time: **Mondays: 1:45 -3:15 p.m.**
**:** **Quarter 1: September 18, 25; October 2, 9, 16, 23; November 6**
**Quarter 2: November 13, 20, 27; December 4, 11, 18; January 8**
**Quarter 3: January 22, 29; February 5, 12, 26; March 5, 12**
**Quarter 4: March 19, 26; April 9, 16, 23; May 7, 21**
Method of Transportation: **Parents provide transportation home at 3:15 p.m.**
**Student Cost: $81.00 /Quarter:**

I ________________________________ hereby grant my permission for my child,________________________, ____________
(Parent or guardian's name) (Child's Name) (Teacher, Grade)
to participation in the above named activities including the method of transportation. In consideration of my child's participation, I agree to indemnify St. Vincent de Paul parish/school and the Archdiocese of St. Paul/Minneapolis from any claims or lawsuits brought against St. Vincent de Paul parish/school/Archdiocese of St. Paul/Minneapolis by myself, my child or others, that arises out of any behavior by my child at the event/activity described above. I also agree to pay reasonable attorney's fees or expenses incurred by the parish/school and Archdiocese in defense of such a claim/lawsuit.

I understand that this event will take place away from the school grounds and that my child will be under the supervision of the St. Vincent de Paul School employee and/or volunteers.

**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.
**EMERGENCY MEDICAL TREATMENT:** In the event of an emergency, I hereby 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.

Hospital (Preferred)________________________________________________________________

Family doctor: ______________________________________________ Phone: ______________________

Family Health Plan Carrier:____________________________________ Policy #: _____________________
In event that my child becomes ill with symptoms such as headache, vomiting, sore throat, fever, diarrhea, I want to be called collect (with phone charges reversed to myself). 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.
**SPECIAL MEDICAL INFORMATION:**
Allergic reactions (medications, foods, plants, insects, etc):_____________________________________

Any physical limitations?_____________________________________________________________

You should be aware of these special medical conditions of my child:______________________________

X_______________________________________________________ ________________
**Parent/Guardian's Signature** **Date**
Home address:_________________________________________________________________________

Home #_________________________ Work #________________________ Emergency# ____________________

E-mail: ______________________________________________________________________________

In the event of an emergency, if you are unable to reach me at the above numbers, contact:

_____________________________________________________ Phone:_________________________
(emergency name & relationship)

STUDENT: By signing this consent form I agree to abide by St. Vincent de Paul's Code of Conduct described in the School Handbook.

X_______________________________________________________ ________________ ________________
**(Student Signature)** **(Date)** **(Teacher/Grade)**

**PLEASE RETURN THIS FORM AND FEE BY: MONDAY, September 18, 2017**