FIELD TRIP PERMISSION FORM

ARCHDIOCESE OF WASHINGTON – St. Louis de France

Participant's Name: _____ Sex: _____ Birth Date: _____

Print Student's Legal Name *MaleFemale*

Parent/Guardian Name: _____

Home Address: _____

_____

Home Phone: _____ Alt. Phone: _____

Consent and Release of Liability

I, _____ , grant permission for my child, _____ ,
Parent/Guardian's Full Name *Participant's Name*

to participate in St. Louis de France events that may require transportation to a location away from the parish site. These activities will take place under the guidance and direction of parish employees and/or volunteers from **St. Louis de France**.

A brief description of the activities follows:

For all activities of the group from
October 1st, 2023 to July, 4th 2024

As parent and/or guardian, I remain legally responsible for any personal actions taken by the above named minor ("participant").I understand that participation in Scouting activities involves the risk of injury due to the nature of theactivities offered. I also understand that participation in these activities is entirely voluntary and requiresparticipants to follow instructions and abide by all applicable rules and the standards of conduct.

With appreciation of the dangers and risks associated with programs and activities including preparations for and transportation to and from the activity, on my own behalf and/or on behalf of my child, I hereby fully and completely release and waive any and all claims for personal injury or loss that may arise against the St. Louis de France, the local council, the activity coordinators, and all employees, volunteers, related parties, or other organizations associated with any program or activity.

Name of Parent/Guardian: _____
Print Parent/Guardian Full Name

Signature of Parent/
Guardian: _____ **Date** _____
Today's Date

Medical Information and Acknowledgment

Parent/Guardian Acknowledgment: 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 or surgical treatment. I wish to be advised prior to any non-emergency treatment by the hospital or doctor.

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

Name: _____Relationship to Participant:_____
Print Full Name of Emergency Contact
Phone No. _____**-** Alt.Phone No. **(____) - Ext.** _____

Health Care Provider: _____Policy No.:_____
Primary Physician: _____

Signature of Parent/
Guardian: _____**Date**_____
Sign Your Name *Today's Date*

Non-Emergency Medical Treatment (If Applicable): In the event it comes to the attention of the parish, its officers, directors and agents, and the Archdiocese of Washington, chaperons, or representatives associated with the activity that my child becomes ill with symptoms such as headache, vomiting, sore throat, fever, diarrhea, I want to be notified immediately.

Signature of Parent/
Guardian: _____**Date**_____
Sign Your Name *Today's Date*

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

Provide medication name(s) and dose(s) here:

Signature of Parent/
Guardian: _____**Date**_____
Sign Your Name Today's Date *Today's 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.

Signature of Parent/
Guardian: _____**Date**_____
Sign Your Name *Today's Date*

I hereby grant permission for non-prescription medication (such as non-aspirin products, i.e. acetaminophen or ibuprofen, throat lozenges, cough syrup) to be given to my child, if deemed appropriate.

Signature of Parent/
Guardian: _____**Date**_____
Sign Your Name Today's Date *Today's Date*

Specific Medical Information: The school 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: _____

Does the participant have a medically prescribed diet? NO YES

Any physical limitations? NO YES

Is child subject to chronic homesickness, emotional reactions to new situations, sleepwalking, fainting?
NO YES _____

Has the participant recently been exposed to contagious disease or conditions, such as mumps, measles, chicken pox, etc.? NO YES Disease: _____ Date: _____

NOTE: The St. Louis de France Scouts and local councils cannot continually monitor compliance of program participants or any limitations imposed upon them by parents or medical providers. List any restrictions imposed on a child participant in connection with programs or activities below and counsel your child to comply with those restrictions.

You should be aware of other special medical conditions of my child:

_____

_____

In case of an emergency involving my child, I understand that efforts will be made to contact me.

In the event I cannot be reached, permission is hereby given to the medical provider to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for my child. Medical providers are authorized to disclose protected health information to the adult in charge and/ or any physician or health care provider involved in providing medical care to the participant. Protected Health Information/Confidential Health Information (PHI/CHI) under the Standards for Privacy of Individually Identifiable Health Information, 45 C.F.R. §§160.103, 164.501, etc. seq., as amended from time to time, includes examination findings, test results, and treatment provided for purposes of medical evaluation of the participant, follow-up and communication with the participant's parents or guardian, and/or determination of the participant's ability to continue in the program activities.

Signature of Parent/
Guardian: _____**Date**_____
Sign Your Name *Today's Date*