PARENT REQUEST TO PARTICIPATE & MEDICAL RELEASE FORM

Dear Parent or Legal Guardian:

Your son/daughter is eligible to participate in a church/school-sponsored event. This activity will take place under the guidance of __Ray Lacy_____. from Diocesan Pastoral Center. A brief description of the activity follows:

Name of Event: _ **March for Life Rally**

Destination: **Washington DC**

Designated Supervisor of Activity:_____

Date and Time of Departure: **January 22, 2020 5pm**

Method of Transportation: **Charter Bus**

Approximate Cost**: $365.00**

If you would like your child to participate in this event, please complete, sign, and return the following statements of consent and release of liability. As parent or legal guardian, you remain fully responsible for any legal responsibility that may result from any personal actions taken by the named student.

I hereby consent to participation by my child, _____
In the event described above. I understand that this event will take place away from the church/school grounds and that my child will be under the supervision of the designate chaperons on the stated dates. I further consent to the conditions stated above on participation in this event, including the method of transportation.

_____
Print Parent's Name

_____
Parent's Signature Date

SWORN TO and subscribed before me on this _____ day of _____ 20_____

_____
NOTARY PUBLIC
(Seal)

My commission expires: _____

YOUTH

Youth Trips & Other Functions

MEDICAL RELEASE AND INFORMATION FORM

(Medical Information for Overnight Trips/Retreats Only)

Name of participant_____ DOB _____

Medication presently on (Name and dosage for each)

_____

_____

_____

Allergies (Foods, Medication, etc.):

_____

_____

_____

Any other Medical conditions (asthma, diabetes, seizures etc)

_____

_____

_____

Date of last tetanus shot _____

_____

Parent contact: Parents Home Phone Work Phone Cell Phone

Contact Person (alternate) Home Phone Work Phone Cell Phone

I hereby give my permission for my child to be administered medical help in case of an emergency. If you have medical insurance please indicate the following:

Insurance Company: _____ Phone: _____

Policy Name: _____ Policy Number: _____

Family Doctor: _____ Doctor's Phone Number: _____

Parents(s) Guardian(s) signature _____ Date: ___ / ___ / _____

Sworn To and subscribed before me on this _____ day of _____ 20_____

_____

Notary Public (seal)

My commission expires: _____