DIOCESE OF CHARLOTTE, NORTH CAROLINA

PARENTAL/LEGAL GUARDIAN PERMISSION FORM FOR FIELD TRIP PARTICIPATION

Dear Parent or Legal Guardian,

Your son/daughter, guardianship is eligible to participate in a Diocesan-sponsored activity that requires personal transportation to locations away from your home site. This activity will take place under the guidance and supervision of adult chaperones. A brief description of the activity follows:

ACTIVITY: _____

DESIGNATED SUPERVISOR OF ACTIVITY: _____

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

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

I give my permission for my child, in case of an emergency, to be taken to a physician or hospital by either the supervisor in charge or by an adult chaperone. I understand that every effort will be made to contact me. If I cannot be reached, however, I hereby give permission to the physician selected by the supervisor in charge or adult chaperone(s) to hospitalize and secure proper treatment (including surgery) for my son/daughter. The cost of any necessary medical care or treatment for my son/daughter will be my expense.

Parent's or Legal Guardian's Signature _____

Date _____

Phone number where you can be reached in case of emergency _____

Accident/Hospitalization Policy Name _____

Policy Number _____

Other Health Info (Allergies etc.) _____

Please complete and return this entire form by: _____

Other information:

HEALTH HISTORY FORM **TODAY'S DATE** _____

Child's Name _____ Date of Birth _____

Address _____ Phone _____

Parent's Name _____ Work Phone _____

Emergency Contact Name _____ Phone _____

Physician Name _____ Phone _____

Medical Insurance Company Name _____ Policy # _____

A. Illnesses and Injuries (Circle all that apply)

Asthma	Diabetes	Epilepsy	Kidney Disease
Convulsions/Seizures	Ear Infection	Heart Disease	

Date of Last Health Exam _____ Any Medical Problems Noted? _____

If yes, please explain _____

Since child's last exam has he/she had:

A serious illness? _____ What? _____

An illness lasting longer than a week? _____

An operation or fracture? _____

Treatment in a hospital or emergency room? _____

Restrictions from physical activity? _____

Medication to be taken on a regular basis? _____

B. Allergies (Circle all that apply)

Animals	Medicines	Insect Stings	Food
Plants	Hay fever	Pollen	Other

Please specify if any are any circled _____

C. Immunizations

	Year primary series completed	*Year of last booster*
DPT	_____	_____
Measles	_____	_____
Mumps	_____	_____
Oral Polio	_____	_____
Rubella	_____	_____
Tb Tine	_____	_____
Chicken Pox	_____	_____
Hib Hepatitis	_____	_____

D. Other health conditions: _____

E. Permission to seek medical help: If I cannot be reached in case of emergency, the bearer of this form is authorized to act on my behalf to seek medical treatment as they deem necessary for my child.

Signature of parent/guardian _____ Date _____