Church of St. Raphael - HUNGER 2019 at St. Bonaventure

PLEASE RETURN BY JANUARY 23, 2019 – Info Meeting on this day at 6:00 PM in Marian Hall

PARENTAL CONSENT FORM & INDEMNITY AGREEMENT

Student/Participant Name: _____

Date of Birth: ___/___/___ Sex: M / F Current Grade in School 8th / 9th / 10th / 11th / 12th

Parent/Guardian Name _____

Home Address _____

Home Phone _____ Cell Phone _____

Email: _____

Please let us know your T-Shirt Size: S, M, L, XL, XXL, XXXL

Date of Event/Field Trip: **HUNGER (Mar. 8-9, 2019)**
Type of Field Trip: **HUNGER 2019**
Destination: **St. Bonaventure / Feed My Starving Children - Eagan / Other Service Locations TBA**
Mode of Transportation: **Carpooling or busing**
Student Cost: **$15.00 per participant ($30.00 Family Max)**
Individual(s) in Charge: **Anna Scherber / Josh Stegman**
Time: **HUNGER** drop off on Fri. Mar. 8 at 5:00 PM / pick up at 7:00 PM on Sat. Mar. 9 (we may carpool to St. Bonaventure – more details to come)

I, _____, grant permission for _____
Parent or Guardian Name Child Name

to participate in the above named activity and I warrant that my child is in good health. In consideration of my child's participation, I agree to indemnify the *Church of St. Raphael, participating parishes, and the Archdiocese of St. Paul & Minneapolis* from any claims or law suits brought against the *Church of St. Raphael, participating parishes, and the 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 *Church of St. Raphael, participating parishes, and the Archdiocese of St. Paul & Minneapolis* in defense of such a claim/suit. Should photos or video be taken, I give my permission for the use of my child's image and /or likeness in any promotional or other marketing activities relating to the youth ministry programs of the *Church of St. Raphael*.

EMERGENCY MEDICAL TREATMENT: In the event of an emergency, I give permission to transport my child to a hospital for medical treatment. I wish to be advised prior to any further treatment by a doctor or hospital. In the event of any emergency, if you are unable to reach me at the above numbers, contact

_____ _____
Name Emergency Phone Number

MEDICAL INFORMATION:

Medication my child is taking at present _____

Family Health Plan carrier number _____

Family Doctor _____ Phone Number _____

As Parent or Guardian, I agree to all of the above stated considerations and conditions.

_____ _____
Parental Signature Date

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 that are applicable.)**

Medical Treatment: In the event it comes to the attention of the Church of St. Raphael its officers, directors and agents, and the Archdiocese of Saint Paul & Minneapolis, 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 called.

Signature: _____ Date: _____

Medications: 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 indicated on attached Prescription Drug & Medical Authorization Form.

Signature: _____ 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: _____ 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: _____ Date: _____

Specific Medical Information: Church of St. Raphael 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 child have a medically prescribed diet? _____

Any physical limitations? _____

Has child recently been exposed to contagious disease or conditions, such as mumps, measles, chickenpox, etc.? If so, date and disease or condition:_____

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

CODE OF CONDUCT

The following are a few rules that all participants are expected to follow while participating and representing *Church of St. Raphael* in this event sponsored by *Church of St. Raphael* on Mar. 8-9, 2019

Please read and sign.

I, _____, WILL:
Printed Name of Youth Participant

- Treat all other persons with respect and not cause any intentional harm (physically, emotionally, or spiritually) to any person in any way.
- Respect the property of others, including all program facilities and property.
- Follow all appropriate instructions of all personnel aiding in this event, including, but not limited to, chaperones, support staff, transportation personnel and administration.
- Be on time for all check-ins and departure time.
- Not have in my possession any tobacco, alcohol or any controlled illegal substance
- Will leave Ipods, MP3's, Video Games, and other electronics at home.

I agree that if any of these terms are violated, *Church of St. Raphael* can send the participant home at the participant/guardian's expense.

_____ _____
Youth Participant Signature Date

_____ _____
Parent/Guardian Signature Date

Please return this form and the $15.00 fee ($30.00 family max)
to the St. Raphael Youth Ministry Office
By Wednesday Jan. 23, 2019
Church of St Raphael
7301 Bass Lake Road
Crystal, MN 55428

CHURCH OF ST. RAPHAEL
PRESCRIPTION DRUG AND MEDICINE AUTHORIZATIONS
(USE THIS FORM *ONLY* IF MEDICATION IS TO BE GIVEN DURING THE EVENT)

The following information must be completed before medicine is given.

Student Name_____

Name of Prescription/Medicine _____

Prescribing Doctor _____

Amount of Dosage _____

Times to be Given _____

Duration of Prescription _____

I, _____, herby authorize the Hunger Adult Chaperon's to
Parent/Guardian

dispense medicine to _____ as directed above.
Student

_____ _____

Signature of Parent/Guardian Date