

**Permission Form and payment due to Freeport or Melrose Parish Center by August 4!**



**FMSC & Valleyfair Day**  
Event for students in grades 6-12



Type of event: Feed My Starving Children & Valleyfair Day

Date of event: August 10<sup>th</sup>, 2017 Cost: \$40 Location: Chanhassen & Shakopee

Event Coordinator: Kristen Neuman youthministry@stmarysofmelrose.com

Estimated departure/return: 7:15am-9pm 7:15 pick up-Melrose 7:30 pick up-Freeport

Transportation: Bus Bring: Bag lunch and/or money for food/vendors

**Please contact Kristen if you can chaperone this event! (320) 249-3032**

(Cut and keep top portion for your reference)



**FMSC/Valleyfair 2017 Permission Form**

Participant's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Grade: \_\_\_\_\_ Sex: \_\_\_\_\_

Parent/Guardian's Name: \_\_\_\_\_

Home Address: \_\_\_\_\_

Primary Phone: \_\_\_\_\_ Student Cell Phone: \_\_\_\_\_  
(Only for day of event, if necessary)

Parent Primary Email Address: \_\_\_\_\_  
*(E-mail will be the primary means of communication for providing details prior to the event.  
If you prefer another form, please contact the event coordinator.)*

I, \_\_\_\_\_ grant permission for my child, \_\_\_\_\_  
Parent or guardian's name Child's name

to participate in this parish/school event that requires transportation to a location away from the parish/school site. This activity will take place under the guidance and direction of parish employees and/or volunteers from One In Faith Community/Tri-Parish. As parent and/or legal guardian, I remain legally responsible for any personal actions taken by the above-named minor ("participant"). I agree on behalf of myself, my child named herein, or our heirs, successors, and assigns, to hold harmless and defend One In Faith Community, its officers, directors, employees and agents, and the Arch/Diocese of Saint Cloud, its employees and agents, chaperons, or representatives associated with the event, from any claim arising from or in connection with my child attending the event or in connection with any illness or injury (including death) or cost of medical treatment in connection therewith, and I agree to compensate the parish/school, its officers, directors and agents, and the Arch/Diocese of Saint Cloud, its employees and agents and chaperons, or representative associated with the event for reasonable attorney's fees and expenses which may incur in any action brought against them as a result of such injury or damage, unless such claim arises from the negligence of the parish/school or the Arch/Diocese of Saint Cloud.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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PERMISSION FORM (Continued)

**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 or surgical treatment. I wish to be advised prior to any further 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: \_\_\_\_\_

Phone: \_\_\_\_\_ Family doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

Family Health Plan Carrier: \_\_\_\_\_ Policy #: \_\_\_\_\_

**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 as follows: \_\_\_\_\_

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

**Specific Medical Information:** The parish/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 child have a medically prescribed diet? \_\_\_\_\_

Does child have any physical limitations? \_\_\_\_\_

Is child subject to chronic homesickness, migraines, fainting, other? \_\_\_\_\_

Has child recently been exposed to contagious disease or conditions, such as mumps, measles, chicken pox, etc.? If so, list date and disease or condition: \_\_\_\_\_

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

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

*Thank You!*