Permission form due to the Tri-Parish office, Freeport, by Feb 26, 2025

Movie Night Event

Youth Permission Form

Event for students in grades 6-12

Type of Event: *Movie Night* **Time:** *6:30-8:30*

Individual in Charge: *Alyssa Hoeschen 320-429-0770 or youthministry@catholic-centered.org*

Date of Event: *March 10, 2025* **Location:** *Freeport Church Basement*

Cost: *Free*

Transportation: *No transportation for this event*

Bring*/wear:* *Chairs/ Blankets/ extra snacks*

Please contact Alyssa if you can chaperone this event! 320-429-0770

Movie Night 2025 Permission Form

Participant's Name: _____ Date of Birth: _____ Grade:____ Sex:___

Parent/Guardian's Name: _____

Home Address: _____

Primary Phone:_____ Student Cell Phone:_____

Parent Primary Email Address:_____

I, _____, grant permission for my child,_____.
(parent/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/school employees and/or volunteers from ____***Tri-Parish***_____.
Name of Parish/School

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 the Tri-Parish, its officers, directors, employees and agents, and the Arch/Diocese of St. Cloud, its employees and agents, chaperones, 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 St. Cloud, its employees and agents and chaperones, 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 St. Cloud.

Signature: _____ Date: _____

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 #: _____

Other Medical Treatment: In the event it comes to the attention of the parish/school, its officers, directors and agents, and the Arch/Diocese of Saint Cloud, 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.***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, emotional reactions to new situations, sleepwalking, bedwetting, fainting?

_____

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!