# Diocese of Great Falls-Billings

Events, Travel, and Permission Policy

## Parental/Guardian Consent Form

| | |
|---|---|
| **Youth/Participant:** | |
| **Birth Date:** | **Sex:** |
| **Parent/Guardian Name:** | |
| **Home Address:** | **City/Zip:** |
| **Home Phone:** | **Alternate Phone:** |

I, (parent/guardian name) grant permission for my child, (youth name) to participate in this event, which may or may not require travel away from the parish/school site. This activity will take place under the guidance and direction of the employees and/or volunteers of the parish, school, or the Diocese of Great Falls-Billings.

| | |
|---|---|
| **Type of event:** | **Date of event:** |
| **Location of event:** | **Cost of event:** |
| **Individual in charge of group:** | |
| **Estimated time of departure:** | **Estimated time of return:** |
| **Mode of transportation to and from event (if necessary):** | |

As a 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 all Catholic Parishes and Catholic Schools of the Diocese of Great Falls-Billings, their officers, directors, employees and agents, and the Diocese of Great Falls-Billings 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 Diocese of Great Falls-Billings, its employees and agents and chaperones, or representatives 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 Diocese of Great Falls-Billings.

| | |
|---|---|
| **Signature:** | **Date:** |

# Diocese of Great Falls-Billings

Events, Travel, and Permission Policy

## Student Medical Information

☐ **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 to Youth:** | **Phone** |
|---|---|
| | |
| **Family Doctor:** | **Phone** |
| | |
| **Family Health Plan Carrier:** | **Policy Number** |
| | |

☐ **Other Medical Treatment:**

In the event it comes to the attention of the parish, school, or Diocese of Great Falls-Billings, their officers, directors, agents, chaperones, 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 medications at present. My child will bring all such medications necessary and such medications will be well-labeled. *All prescription medication will be in original prescription packaging.* Names of all medications and concise directions for seeing that the child takes such medications, including dosage and frequency of dosage are attached to this document.**

☐ **No Medication:**

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.

☐ **Non-Prescription Medication:**

I hereby grant permission for non-prescription medication to be given to my child, if deemed appropriate.

**Parent/Guardian Signature** **Date**

# Diocese of Great Falls-Billings

Events, Travel, and Permission Policy

## Specific Medical Information:

The following information will be held in confidence and
will only be shared for the safety and wellbeing of your child.

| |
|---|
| **Youth/Participant:** |
| **Allergic reactions (medications, foods, plants, insects, etc.):** |
| **Physical limitations:** |
| **Does your child have a medically prescribed diet? If so, please describe:** |
| **Has your child recently been exposed to any contagious disease or conditions?**<br>**If so, please list date of exposure and disease or condition:** |
| **Date of last tetanus/diphtheria immunization:** |
| **Is your child subject to chronic homesickness, emotional reactions to new situations, sleepwalking, bedwetting, fainting?** |
| **Please list any other special medical conditions your child may have:** |

| | |
|---|---|
| **Parent/Guardian Signature** | **Date** |