



PARENT / GUARDIAN

SCHOOL PERMISSION SLIP / MEDICAL AUTHORIZATION / INDEMNITY AGREEMENT

INS-607 A Revised 5-14-08

SPONSOR OF ACTIVITY: \_\_\_\_\_ SCHOOL: \_\_\_\_\_
ACTIVITY: \_\_\_\_\_ COST PER STUDENT: \_\_\_\_\_
DATE(S) OF ACTIVITY: \_\_\_\_\_ TIME OF DEPARTURE: \_\_\_\_\_ TIME OF RETURN: \_\_\_\_\_
PLACE OF ACTIVITY: \_\_\_\_\_ METHOD OF TRANSPORTATION: \_\_\_\_\_
CURRICULUM JUSTIFICATION: \_\_\_\_\_

The undersigned as parent or legal guardian of \_\_\_\_\_, does hereby give permission for the above named individual to attend the described activity.

As a condition of attending the described activity, I do hereby release the Roman Catholic Archdiocese of Santa Fe and all its affiliated parishes, schools and organizations, as well as their officers, agents and employees, from any and all claims, demands, actions, or causes of action due to death, injury, or illness, in any way, arising from the above described activity, including, but not limited to transportation to and from the event.

I further agree that the financial responsibility for securing care, in case of injury resulting from participation in the program, is a matter between the participant and his/her health care provider, and that the Archdiocese of Santa Fe cannot pay health care providers for treatment of any injuries. It is further agreed, that the participant will assume all legal responsibility for their personal safety and actions while participating in the program and while traveling to and from the program activities.

I hereby authorize the Supervisor of the activity or his/her designee to act in my behalf to authorize such medical attention, surgery, or other health care services, as may be recommended in an emergency situation while participating in the activity. If the below named physician cannot be reached, I hereby authorize any licensed physician or medical center to treat my child.

I hereby authorize the Supervisor of the activity or his/her designee to administer the following medication to my child according to the instructions described here:
Medication \_\_\_\_\_
Directions: \_\_\_\_\_
If the medication is prescribed by a doctor, the prescription in its original container will be provided to the Supervisor of the activity.

Name of Physician \_\_\_\_\_ Phone \_\_\_\_\_

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

Phone: \_\_\_\_\_ Home \_\_\_\_\_ Work \_\_\_\_\_