

NET Lifeline Teen Mass Permission Form - 2009-2010

Church of St. Joseph- Waconia, MN

PARENTAL CONSENT FORM & INDEMNITY AGREEMENT

Student/Participant Name: _____

Date of Birth: ___/___/___ Sex: M / F Grade in School (09-10) 8 9 10 11 12

Parent/Guardian Name _____

Home Address _____

Home Phone _____ Cell Phone _____

Date of Event/Field Trip: (Please circle date below)

Nov. 7 2009 / Dec. 5, 2009 / Jan. 9, 2010 / Feb. 6, 2010 / Mar. 6, 2010 / Apr. 10, 2010 / May 1, 2010

Type of Field Trip: **NET Life Line Mass & Youth Program**

Destination: **NET Center – 110 Crusader Ave. W. West St. Paul MN**

Individual(s) in Charge: **Stephanie Crowley**

Drop-off Time: **4:00 PM** at St. Joseph (front of Education Center) Pick-up Time: **11 PM** at St. Joseph

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. Joseph, other participating parishes, and the Archdiocese of St. Paul & Minneapolis* from any claims or law suits brought against the *Church of St. Joseph, other 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. Joseph, other participating parishes, and the Archdiocese* 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 *Church of St. Joseph or other participating parishes*.

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

OPTIONAL 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.

Signature Date

I would consider chaperoning this event: YES NO