PERMISSION SLIP

1. Consent: I grant my permission for my child _____ to attend and participate in 2018 YOUTH SUMMIT
[SCHOOL SPONSORED and/or CHURCH SPONSORED ACTIVITY]
(hereinafter referred to as "Activity") to be held at Rock Valley College, Rockford on
10-28-18
[INCLUSIVE DATE OR DATES]
[LOCATION]

2. Student Cooperation: My child agrees to abide by all the rules of aforementioned Activity and to obey the staff in charge of this Activity. The Parish, School, and Diocese will not be liable for my child's failure to cooperate and/or to abide by the rules. Any infraction of the rules may result in the immediate dismissal of my child from the Activity at my expense and without refund to me of the costs paid for the Activity.

3. First-Aid/Emergency Treatment: I authorize the School, Parish, and Diocese and its employees and volunteers to administer first-aid to my child if deemed necessary and appropriate to preserve the life, limb or well-being of my child. I authorize the Parish, School, and Diocese to contact and engage medical personnel and arrange for emergency treatment of my child, including transportation for medical, dental, surgical or hospital care or diagnosis, and I consent to that treatment for my child. I agree that I am financially responsible for such medical treatment.

4. Administration of Medication provided by parent/guardian of child: If my child needs to take prescription or non-prescription medication during this Activity, I have provided the medication in its original container. I give permission to an adult employee or adult volunteer to administer the medication or assist in the administration of the medication to my child in the dosage prescribed by the prescription or, for non-prescription medication, the dosage recommended on the container by the manufacturer. If there are explicit instructions for this medication, I state them here:
_____
_____.

5. Release: I hereby release and discharge The Diocese of Rockford and its Bishop, and the Parish and School, and the officers, directors, employees, and volunteers of same, from all claims for personal injuries or property damage that I or my child may suffer while my child is attending and/or participating in the Activity, unless the injuries or damage resulted from willful misconduct of the Diocese, the Parish, the School or its employees. If I have provided medication for my child to take during this Activity, I hereby release and discharge The Diocese of Rockford and its Bishop, and the Parish and School, and the officers, directors, employees, and volunteers of same, from all claims for personal injuries or property damage that I or my child may suffer as a result of the administration of or lack of administration of or assistance in or lack of assistance in the administration of said medication to my child, whether by my child and/or an adult employee and/or an adult volunteer; unless the injuries or damage resulted from willful misconduct of the Diocese, the Parish, the School or its employees.

Date: _____

Parent/Guardian's Signature: _____

Name: _____
[PLEASE PRINT]

Effective September 17, 2015
Revised January 1, 2016

STUDENT OR YOUTH EMERGENCY INFORMATION

PARISH/SCHOOL/DIOCESAN ENTITY: _____ CITY: _____

FAMILY NAME_____

Only ONE EMERGENCY INFORMATION form per family unit is necessary.

Full Name of Child	Sex	Date of Birth	Special Health Condition (describe) or Medication prescribed or Dietary needs, etc.

Home Address: _____ Phone: _____

Name of Mother/Guardian: _____ Place of Employment: _____

Mother's work number: _____ Cell Number: _____

Name of Father/Guardian: _____ Place of Employment: _____

Father's work number: _____ Cell Number: _____

If divorced, name of legal custodial parent: _____

_____

Do Mother and Father have Joint Custody? (Y/N) _____

If custodial parent cannot be reached, may we contact non-custodial parent?, (Y/N) _____

RESPONSIBLE ADULT(s) who have agreed to assume responsibility for child, if parent/guardian cannot be reached.

Name	Address	Phone	Relationship to Child

Physician of Choice: _____
Address: _____
Phone: _____

Hospital of Choice: _____
Address: _____
Phone: _____

If I, or responsible adult, and physician of choice, as indicated above, cannot be reached in an emergency and immediate medical and/or hospital attention is indicated I hereby authorize the transporting of my child to a hospital or physician for treatment.

Date: _____

Signature: _____

Print name: _____