Bishp Chatard High School Community Service Day

Friday, April 16, 2021

STUDENT _____ HOME PHONE_____

MOTHER'S NAME _____FATHER'S NAME _____

EMERGENCY PHONE #'S_____OR_____

INSURANCE INFORMATION: (Both lines MUST be completed.)

Family Health Insurance Company: _____

Policy Number: _____

MEDICATIONS: If medications are needed, please send them with your child. List these medications in the following section and include product name and physician's instructions on dosage and frequency. **Any medications brought to the program should be clearly labeled in their original container and checked-in at registration.**

Health Limitations/Conditions: Please list any limitations and/or conditions regarding your child's health of which we should be aware.

PARTICIPATION CONSENT:

I grant **permission for my child to participate** in the Community Service Day I will not hold Bishop Chatard High School place of service responsible in the event of any injury or accident to my son or daughter while participating in or traveling to and from the event. I warrant that, to the best of my knowledge, my child is in good health and able to participate in all program activities. (Please submit a statement indicating limitations and/or conditions of which we should be aware.)

I agree that **my child shall abide by all Bishop Chatard rules and policies.** I have reviewed and discussed the rules and policies with my child prior to signing this form. I agree that if my child fails to abide by the rules/policies, or engages in a serious infraction, he or she may be immediately dismissed from the activity with no refund, and sent home at my expense. I agree to my child's participation in the Community Service Day.

I understand that all **prescription and non-prescription medication will remain in the possession of the adult team leader** and be dispensed as prescribed. **In case of medical emergency**, I understand that every effort will be made to contact parents or guardian of participants. In the event that I cannot be reached, I hereby give permission to the Campus Ministry program directors to seek treatment for my son/daughter. I hereby give permission to the medical staff to hospitalize, secure proper treatment for, and to order injection, anesthesia, or surgery for my child.

I understand that my child may be photographed, unidentified in group situations; and I hereby grant permission for my child to be photographed & identified for releases to *Bishop Chatard* and the Bishop Chatard website and/or other promotions.

I understand that, as situations change due to COVID concerns, other permission slips may be needed, as procedures require.

Parent/Guardian Signature:_____ Date:_____

Name: (Printed)_____ Email:_____