

Bishop Chatard High School
Permission to attend Archbishop's Mass
November 28, 2018

STUDENT NAME _____ HOME PHONE _____

MOTHER'S NAME _____ FATHER'S NAME _____

EMERGENCY PHONE #(s) _____ / _____

INSURANCE INFORMATION: (Both lines MUST be completed.)

Family Health Insurance Company:

Policy Number:

MEDICATION: 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. **Medications brought to the retreat must be clearly labeled in their original container and checked-in at registration.**

1. _____
2. _____

_____ **Please check if you give permission for us to dispense Tylenol/Advil as needed.**

PARTICIPATION CONSENT:

I grant **permission for my child to participate** in the Archbishop's Senior Mass. I will not hold Bishop Chatard High School or the Archdiocese of Indianapolis responsible in the event of any injury or accident to my child while participating in the Mass and/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 agree that if my child fails to abide by the rules/policies, or engages in a serious infraction, he or she will be subject to Bishop Chatard discipline policies.

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 Director of Campus Ministry to seek treatment for my child. 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.

Parent/Guardian Signature: _____ **Date:** _____

Name: (Printed) _____ **Phone:** _____

Please return this form to Mrs. Wagner no later than Friday, November 23, 2018