Youth Ministry 2018 - 2019 Field Trip
Statement of Consent

I hereby give consent for my child, _____, in all field trips in the 2018 - 2019 Youth Ministry group at Saint Luke University Parish, 10144 42nd Avenue, Georgetown Twp., MI 49428. I understand that the event will take place away from the school/parish grounds. I further consent to the conditions stated on the 'Youth Ministry ***Field Trip Information***' page regarding field trips, including transportation to and from these trips.

In consideration of my child being allowed to participate in field trips, I agree to waive and release, and indemnify and hold harmless St Luke University Parish, any and all affiliated organizations, its/their employees, agents, representatives, volunteers and drivers, from any and all claims I or my child may have, excluding claims for intentional misconduct or gross negligence, arising from or relating to my child's participation in this event.

I authorize St Luke University Parish to obtain necessary medical treatment for my child in case of illness, injury, or accident.

In the case that we need to contact a parent/guardian during a field trip, please provide us with the name(s) and phone number(s):

1. **Main Contact**

   Name: _____ Contact #: _____

2. **Secondary**

   Name: _____ Contact #: _____

Parent

I certify that I am the (*check one*) _____ custodial parent _____ legal guardian of the minor child named above, and I agree to the above terms for myself and for my minor child.

_____ _____

(Print Parent's Name) (Parent's Signature)

_____

(Date)

Medical Treatment Release Form

To Whom It May Concern:

As a parent/guardian, I do hereby authorize the treatment by a qualified and licensed physician of any condition, which, in the opinion of the physician, is deemed necessary and appropriate. This authority is granted only after a reasonable effort has been made to reach me.

Name of child: _____ Relationship to you:_____

Reason for which release is intended: _____

Address of Minor: _____

Emergency Phone(s): _____

Family Physician: _____ Phone: _____

Physician's Address: _____

List allergies, medication, contact, or other pertinent comments:

_____

_____

_____

Health Insurance Data:

Company: _____ Policy: _____

Group: _____ Contract: _____

I further authorize the person who presents the minor to sign the Acknowledgement of Receipt of Notice Privacy Rights that may be presented by the physician or health care facility.

This authorization is completed and signed of my own free will with the sole purpose of authorizing medical treatment deemed necessary and appropriate by the treating physician.

Signed: _____ Date: _____
(Parent or Guardian)