



4690 Bald Eagle Avenue  
White Bear Lake, MN 55110  
651-429-7771

Return to School by: \_\_\_\_\_

### FIELD TRIP

#### PARENTAL/GUARDIAN CONSENT FORM AND INDEMNITY AGREEMENT

Participant's Name: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Gender: \_\_\_\_\_

Parent/Guardian's Name: \_\_\_\_\_

Home Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Business Phone: \_\_\_\_\_

Date/Type of Event: \_\_\_\_\_

Destination: \_\_\_\_\_

Individual(s) in Charge: \_\_\_\_\_

Estimated time of departure and return: \_\_\_\_\_

Mode of transportation to & from event: \_\_\_\_\_

Student Cost if applicable: \_\_\_\_\_

Special Instructions: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I, \_\_\_\_\_, grant permission for \_\_\_\_\_  
Parent or Guardian's Name Child's 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 parish/school and the Archdiocese of St. Paul, Minneapolis from any claims or law suits brought against the parish/school/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 parish/school and Archdiocese in defense of such a claim/law suit.

**EMERGENCY MEDICAL TREATMENT:** In the event of an emergency, I give permission to transport my child to a hospital for emergency medical treatment. I wish to be advised prior to any further treatment by a doctor or hospital. In the event of an emergency, if you are unable to reach me at the above numbers, contact \_\_\_\_\_  
(Name) (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)