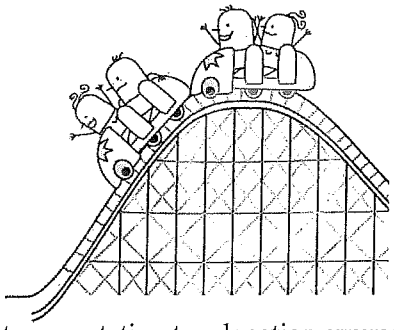
youth group HIGH SCHOOL

Cedar Point Parent Permission Form



Dear Parent or Legal Guardian:

Your son/daughter is eligible to participate in a parish sponsored activity requiring transportation to a location away from the parish grounds. The event described will take place under the guidance of your child's Youth Minister. A brief description of the activity follows:

Name of the Event**: Cedar Point Day Trip**
Destination/Location: **Cedar Point Sandusky, Ohio**
Designated Supervisor(s): **Ginny White (517) 862-3913**
Start Date/Arrival Time: **Meet at St. Martha at 6:30 AM on Wednesday, June 28**
End Date/ Pickup Time**: Pick up at St. Martha at 11 PM on Wednesday, June 28**
Method of Transportation: **Dean Trail ways**
Cost per Student: **$45 per teen for ticket and snack purchase - no extra charge for bus (No Refunds!)**

If you would like your teen to participate in this event, please complete, sign and return the following statements of consent and release of liability by the specified date along with a filled out health form and payment for the event. As parent or legal guardian, you remain fully responsible for any legal responsibility which may result from actions taken by the named student.

(Keep upper portion for your information)

Permission Form for Cedar Point Trip

I hereby consent to have _____ participate in the event described above. I understand that this event will not take place on Parish grounds and that my son/daughter will be under the supervision of the designated parish employee/volunteer on the stated date. Further, I hereby release and discharge the Lansing Region Parishes, staff and volunteers from any liability in the event of injury, casualty, theft or property damage as a result of attending this event.

My teen agrees to abide by all rules as outlined by the designated supervisors and I will not hold the Lansing Region Parishes, staff or volunteers liable if my child fails to cooperate with these rules. I understand that any infractions of those rules may result in immediate dismissal from the event and I will be responsible for any costs or other requirements for my child's immediate transportation home.

Having read this entire form, understanding its contents and implications, I hereby consent to the conditions stated above regarding expectations, participation and method of transportation.

_____ _____ _____

(Printed name of parent/guardian) *(Signature of parent/guardian)* *(Date)*

*Relationship to the child*_____

$45

**** Please return this form, the health form, and ~~$50~~ to parish office or to Ginny White by Tuesday, June 15th. ****

Cedar Point®

HEALTH HISTORY AND MEDICAL RELEASE FORM
FOR PARISH PROGRAMS AND ACTIVITIES

Participant's Name_____ Sex _____ Birth Date _____ Age _____

Parent/Guardian _____ Relationship to participant _____

Street Address _____City _____ State _____ Zip Code _____

Home Telephone ( ) _____ Work Telephone ( ) _____

HEALTH HISTORY

Family Doctor _____ Telephone Number ( ) _____

IMMUNIZATIONS (Record YEAR of last immunization or last time person had disease):

Tetanus/Diphtheria _____	Measles _____	Mumps _____
Chicken Pox _____	Rubella _____	Polio _____
TB _____(results) _____	Hepatitis B _____	Other _____

SPECIAL INFORMATION: (Please check all that apply. Information will be held in strict confidence.)

Sleep Walking _____	Fainting _____	Dizziness _____
Blackouts _____	Asthma _____	Kidney Problems _____
Frequent Nosebleeds _____	Frequent Colds _____	Seizures _____
Severe Headaches _____	Diabetes _____	Severe Homesickness _____
Frequent Earaches _____		

ALLERGIC REACTIONS (Please list all known allergies - plant, insect, food, medicine AND TYPE OF REACTION):

_____

Please indicate any other medical problems/situations pertinent to your child:

_____

Any physical limitations? _____ If yes, explain _____

Any emotional/psychological limitations or reactions to be aware of? ____ If yes, explain:

_____

Is the student presently taking any medication? _____ All medication is to be well labeled with clear, concise directions indicated here (frequently, dosage, etc.):

_____

In an **EMERGENCY,** and if unable to reach parent/guardian, we should contact:

1. Name _____ Telephone Number ( ) _____
2. Name _____ Telephone Number ( ) _____

PLEASE FILL OUT BOTH SIDES

Note to parent/guardian: Please read the following sections carefully. We apologize for the complexity but we must be sure we have your full consent in these areas as well as, having this document notarized.

PERMISSION FOR ROUTINE MEDICAL TREATMENT

All attempts **will** be made to notify you if your child requires medical treatment (i.e., cases of high, persistent fever; severe vomiting, etc.). Please indicate whether or not you wish attempts to be made to contact you if your child becomes ill with minor symptoms (i.e., headache, sore throat, low-grade fever, etc.). **YES** _____ **NO** _____
NOTE: If you do wish to be contacted and it is not a local call, the charges shall be reversed to you.

We do not wish to give any medical treatment to your son/daughter against your wishes or family practice. Please read each of the following statements carefully and **sign only either A or B** which is in accord with your wishes:

A) I grant permission for non-prescription medication (i.e., Tylenol, cough syrup, etc.) except for the following _____ to my student if deemed advisable by the designated supervisor, and I grant permission for routine non-surgical medical care to be given to my student, if deemed advisable by the designated supervisor(s).

* SIGNATURE _____ DATE _____

or

B) I do not want **ANY** type of medication administered to my child unless the situation is life-threatening and emergency treatment is required.

* SIGNATURE _____ DATE _____

PERMISSION FOR EMERGENCY MEDICAL TREATMENT

In case of emergency, I hereby give permission to transport my child to the nearest hospital/emergency center for emergency medical or surgical treatment. I will be contacted as soon as possible and will be advised prior to any further treatment by the hospital or doctor.

*SIGNATURE _____ DATE _____

FAMILY INSURANCE PROVIDER/HEALTH PLAN _____
HEALTH PLAN NUMBER (Include expiration date): _____