

PARENTAL CONSENT/MEDICAL RELEASE FORM

NAME _____ AGE _____ BIRTHDATE _____
ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____
PHONE _____ SCHOOL _____ GRADE _____ CHURCH _____
PARENT (S)/GUARDIANS BUSINESS PHONE _____

I would like to be in a sleep group with _____

EMERGENCY CONTACT (OTHER THAN PARENT/GUARDIAN) _____

To Whom It May Concern:

The undersigned does hereby give permission for _____ to participate in the following activity
(Child's Name)
sponsored by Our Lady of the Lake Parish.

ACTIVITY:	"Lunch Bunch" Middle School Bible Study and Fellowship
WHEN:	Tuesday, July 6 & July 20, 2010 from 12:00-2:00 pm @ Corpus Christi Center Tuesday, August 3 & August 17, 2010 from 12:00-2:00 @ Our Lady of the Lake Garden
WHERE:	Corpus Christi Center Youth Room in July Our Lady of the Lake in August
TRANSPORTATION:	By Parents
COST:	Free
DESIGNATED SUPERVISOR:	Marv Murphv, Director of Youth Ministrv (616) 399-1062 x 113

In consideration of my child being allowed to participate in this "Lunch Bunch", I hereby agree on behalf of myself and my child, to release St. Francis de Sales and Our Lady of the Lake Church, the Roman Catholic (Arch) diocese of Grand Rapids, and any and all affiliated organizations, their employees, agents and representatives, including volunteer drivers (collectively "Releasees"), from any and all claims, including negligence, which may be asserted by me or my child, or on behalf of my child, arising from or relating to my child's participation in the field trip.

We(I) authorize an adult, in whose care the minor has been entrusted, to consent to any X-ray examination, anesthetic, medical, surgical, or dental diagnosis or treatment, and hospital care, to be rendered to the minor under the general or special supervision and on the advice of any licensed physician or licensed dentist on the medical staff of a licensed hospital, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital.

The undersigned shall be liable and agree(s) to pay all costs and expenses incurred in connection with such medical and dental services rendered to the aforementioned child pursuant to this authorization.

Should it be necessary for our (my) child to return home due to medical reasons or otherwise, the undersigned shall assume responsibility for transportation and/or incurred transportation costs.

Insurance Company _____ Policy Number _____

Participant Signature _____ Date _____

Parent(s)/Guardian Signature _____ Date _____

Below please list any allergies or special medical problems your child may have. Thank you.

Please return this Registration form attention Mary Murphy to the Youth Office by 7.1.10