

BISHOP MCGUINNESS CATHOLIC HIGH SCHOOL
PARENTAL/GUARDIAN CONSENT FORM AND LIABILITY WAIVER

Participant's name: _____
Birth date: _____ Sex: _____
Parent/Guardian's name: _____
Home address: _____
Home phone : _____ Business phone: _____

I, _____, grant permission for my child, _____, to participate in this activity that may require transportation to a location away from the activity site. This activity will take place under the guidance and direction of school employees and/or volunteers from Bishop McGuinness Catholic High School. A brief description of the activity follows:

Type of event: _____
Location(s): _____
Individual in charge: _____
Duration of activity: _____
Mode of transportation to and from event: _____

As parent and/or legal guardian, I remain legally responsible for any personal actions taken by the above named minor ("participant").

I agree on behalf of myself, my child named herein, or our heirs, successors, and assigns, to hold harmless and defend Bishop McGuinness Catholic High School, its officers, directors and agents, and the Archdiocese of OKC, coaches, chaperons, or representatives associated with the event, arising from or in connection with my child attending the event or in connection with any illness or injury or cost of medical treatment in connection therewith, and I agree to compensate the school, its officers, directors and agents, and the Archdiocese of OKC, coaches, chaperons, or representatives associated with the activity for reasonable attorney's fees and expenses arising in connection therewith.

Signature: _____ Date: _____

MEDICAL MATTERS: I hereby warrant that to the best of my knowledge, my child is in good health, and I assume all responsibility for the health of my child.

Emergency Medical Treatment: In the event of an emergency, I hereby give permission to transport my child to a hospital for emergency medical or surgical treatment. I wish to be advised prior to any further treatment by the hospital or doctor. In the event of an emergency, if you are unable to reach me at the above numbers, contact:

Name & relationship: _____ Phone: _____
Family doctor: _____ Phone: _____
Family Health Plan Carrier: _____ Policy # : _____
Signature: _____ Date: _____

Specific Medical Information: The school will take reasonable care to see that the following information will be held in confidence.

Allergic reactions (medications, foods, plants, insects, etc.): _____
Immunizations: Date of last tetanus/diphtheria immunization: _____
Does child have a medically prescribed diet? _____
Any physical limitations? _____
Has child recently been exposed to contagious disease or conditions, such as mumps, measles, chickenpox, etc.? If so, date and disease or condition: _____
You should be aware of these special medical conditions of my child: _____
