Catholic Academy of West Buffalo
PARENT/LEGAL GUARDIAN PERMISSION SLIP

Dear Parent or Legal Guardian:

Your son/daughter, guardianship, is eligible to participate in a **Field trip/School event** sponsored by the **Catholic Academy.** These activities will take place under the guidance and supervision of employees from Catholic Academy. A brief description is as follows:

Event/Location: _____

Date and Time of Departure: _____

Date and Time of Return _____

Designated Chaperones: _____

Method of Transportation: _____ **Student Cost:** _____

Other Information: _____

If you would like your child to participate in this event, please complete, sign and return the following statement of consent and release of liability and medical release information. As a parent, legal guardian, you remain fully responsible for any legal responsibility that may result from actions taken by the named student.

LIABILITY RELEASE

I/We recognize and acknowledge that there are risks in my child's presence and participation in the above mentioned event. I agree to indemnify, hold harmless, waive and relinquish all claims I may have against Catholic Academy and the Diocese of Buffalo including any negligence claims on their part and its officers, agents, employees, representatives or volunteers arising out of the transportation to and/or from the event, or in connection with any claims arising out of or caused by any activity my child participates in during the event.

MEDICAL RELEASE

Our permission is hereby given to the representatives of Catholic Academy to authorize by his/her signature, whatever medical or surgical treatment may be considered necessary in the event of an accident or medical emergency in which the parent or guardian cannot be reached. It is understood that every attempt to reach the parent or guardian will be made. If the physician below cannot respond, I authorize any licensed physician or medical center to treat the student designated below.

_____ Student

_____ Parents' Name/Signature

_____ Address

_____ Telephone Number

_____ Emergency Contact/Telephone Number

_____ Primary Care Physician/Phone number

Health Insurance Company/Plan #: ID# _____

RETURN BY: _____