

FRIDAY NIGHT HANG OUT AND BOWLING

Church of St. Albert
11400 57th St. NE
Albertville, MN 55301

Church of St. Michael
11300 Frankfort Parkway
St. Michael, MN 55376

PARENTAL/GUARDIAN CONSENT FORM AND LIABILITY WAIVER

Participant's Name: _____
Home Address: _____
City: _____ State/Zip: _____ Home Phone: _____
Email: _____@_____ School Attending: _____
Date of Birth: ____/____/____ Gender: __Male__ Female Grade in School: _____
Parent/Guardian's Name: _____
Cell Phone: _____

Type/Date of Event: Hang Out and Bowling/Friday January 11th, 2009

Location: St. Albert Youth Room and Monticello Bowling Alley

Time: 6:30pm-11:30pm

Individual in Charge: Cassandra Olson

Mode of Transportation to and from Event: Car Pool to Bowling Alley

Cost: \$10 for bowling

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 and the Archdiocese of St. Paul/Minneapolis from any claims or lawsuits brought against the parish/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 and Archdiocese in defense of such a claim/lawsuit. **As a Parent or Guardian, I agree to all of the above stated considerations and conditions. I also agree to allow any pictures or video's taken during this retreat to be used as promotional material for St. Michael's or St. Albert's Youth Ministry.**

(Signature)

(Date)

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:

Emergency contact person: _____ **Phone:** _____

Medical Information:

Medication my child is taking at present: _____
Family Health Plan Carrier Number: _____
Family Doctor: _____
Any Allergies: _____ Any Physical Limitations?: _____
Is child subject to chronic Homesickness, sleepwalking, or fainting? _____
Does child have medically-prescribed diet?) _____