FORM 13

FIELD TRIP PERMISSION FORM

ARCHDIOCESE OF WASHINGTON – Catholic Schools

Participant's Name: _____ Sex: ☐ ☐ Birth Date: _____
Print Student's Legal Name *Male* *Female* *mm/dd/yyyy*

Parent/Guardian Name: _____

Home Address: _____

_____

Home Phone: ( ) - _____ Alt. Phone: ( ) - **Ext.** _____

Consent and Release of Liability

Type of Event: Aftercare activities for 2025-2026

Date of Event: All year long

Estimated Time of Departure from School: 3:15pm Estimated Time of Return to School: 4:30pm

Cost of the Event: Free

Destination of Event: City Hall Park

Individual(s) In-charge: Mrs. Ruiz, Ms Ro

Mode of Transportation To/From Event: walking

I, _____, grant permission for my child, _____,
Parent/Guardian's Full Name *Print Student's Name*
to participate in this school event that may require transportation to a location away from the school site. This activity will take place under the guidance and direction of school employees and/or volunteers from **<<Type School's Name Here>>**.

As parent and/or 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 **<<Type School's Name Here>>**, its parish, officers, directors, employees and agents, and the Archdiocese of Washington, its employees and agents, chaperons, or representatives associated with the event, from any claim arising from or in connection with my child attending the event or in connection with any illness or injury (including death) or cost of medical treatment in connection therewith, and I agree to compensate the parish, its officers, directors and agents, and the Archdiocese of Washington, its employees and agents and chaperons, or representative associated with the event for reasonable attorney's fees and expenses which may incur in any action brought against them as a result of such injury or damage, unless such claim arises from the negligence of the parish/diocese.

Name of Parent/Guardian: _____
Print Parent/Guardian Full Name

Signature of Parent/Guardian: _____ **Date** _____
Sign Your Name *Today's Date*

ARCHDIOCESE OF WASHINGTON
Rev. October 2016

Medical Information and Acknowledgment

Parent/Guardian Acknowledgment: 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 or to seek medical treatment from available health professionals as necessary. I wish to be advised prior to any non-emergency 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 to Student: _____
Print Full Name of Emergency Contact

Phone No. **( ) -** _____ Alt.Phone No. **( ) - Ext.** _____

Primary Professional (LHCP): _____

LHCP Phone No.: **( ) -** _____

Please Note: In the event a child becomes ill with non-emergency symptoms such as headache, vomiting, sore throat, fever, or diarrhea, chaperones and/or representatives associated will notify parents immediately.

Medications (If Applicable): If your child will require the administration of medication on this field trip aside from emergency medications and those authorized by ADW Student Medication Authorization (Form 8), the medication must be provided to the school, in the original package/container, with a doctor's order, even for over-the-counter medications. Please indicate the names of the medications to be given on the field trip below.

Provide medication name(s) and dose(s) here: _____

_____

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

Allergies (medications, foods, plants, insects, etc.): _____
Does the participant have a medically prescribed diet? ☐ YES ☐ NO If yes, please describe _____

_____

Any physical limitations? ☐ YES ☐ NO If yes, please explain _____

_____

My child has these special current/new medical conditions: conditions, such _____

_____

For overnight trips only: Is your child subject to chronic homesickness, emotional reactions to new situations, sleepwalking, fainting?

☐ NO ☐ YES If yes, please explain _____

_____

No medication of any type, whether prescription or non-prescription, may be administered to my child unless the situation is life threatening and emergency treatment is required.

Signature of Parent/Guardian: _____ **Date** _____
Sign Your Name *Today's Date*

I hereby grant permission for non-prescription medication (such as non-aspirin products, i.e. acetaminophen or ibuprofen, throat lozenges, cough syrup) to be given to my child, if deemed appropriate.

Signature of Parent/Guardian: _____ **Date** _____
Sign Your Name *Today's Date*