PARENT / LEGAL GUARDIAN PERMISSION SLIP GRADES K-2

Dear Parent or Legal Guardian:

Your son/daughter, guardianship, is eligible to participate in the field trip sponsored by St. Joseph School. These activities will take place under the guidance and supervision of employees and volunteers from St. Joseph School. A brief description is as follows:

Event/Location: *Bowling at Mancuso Bowling Center*

Date and Time of Departure: *Wednesday, February 13, 2019 at 8:30 AM*

Date and Time of Return: *Wednesday, February 13, 2019 at 11:30 AM*

Designated Chaperones: *K-2 Teachers and Aides*

Method of Transportation: *walking*

****This is a dress down day. Sneakers or boots should be worn as we walk to events. Pizza lunch will be provided after in the school cafeteria.****

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 St. Joseph School 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

My permission is hereby given to the representatives of St. Joseph School 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 I cannot be reached. It is understood that every attempt to reach me will be made. If the physician below cannot respond, I authorize any licensed physician or medical center to treat the student designated below.

Student _____ Health Insurance Company/Plan #//ID # _____

Address _____ Primary Care Physician/Phone number _____

Emergency Contact/ Telephone Number _____

Allergies, Reactions or other pertinent medical information: _____

Parent/Guardian Name/Signature _____ Telephone Number _____