

**PARENT/LEGAL GUARDIAN  
PERMISSION AND INDEMNITY AGREEMENT  
St. Andrew Dinner**

Location: St. Francis de Sales Seminary

Supervisor of Event: St. Francis de Sales Seminary Staff

Type of Event: Dinner with Fr. Luke Strand, Fr. John Burns, priests, seminarians and other young men in discernment.

Date of Event: Tuesday, December 29, 2020

Method of Transportation: Participant and parents to provide

Name of Son/Ward: \_\_\_\_\_

Parish/School: \_\_\_\_\_ Grade: \_\_\_\_\_

Participant Email (optional): \_\_\_\_\_ Cell Phone (optional): (\_\_\_\_) \_\_\_\_\_

I consent to the participation of my SON /WARD in the above named ACTIVITY.

In consideration for my SON /WARD's participation, I agree to reimburse and indemnify **St. Francis de Sales Seminary** (understood to include the Archdiocese of Milwaukee) for all reasonable legal and court fees incurred by **St. Francis de Sales Seminary** in defending a lawsuit that I or my SON /WARD may bring against **St. Francis de Sales Seminary** which relates to the above named ACTIVITY if St. Francis de Sales Seminary is found not legally liable by the courts and prevails in the lawsuit. If **St. Francis de Sales Seminary** is found legally liable for injuries sustained by SON/WARD, this paragraph will not apply.

I certify that I have an understanding of this agreement and any risks and hazards associated with the ACTIVITY described above that my SON/WARD will be participating in. I further understand that I had the opportunity to fully discuss this agreement with a representative of **St. Francis de Sales Seminary** to clarify any concerns or questions about the ACTIVITY or this agreement that I may have had.

PARENT/GUARDIAN'S NAME(S): \_\_\_\_\_

HOME ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

HOME PHONE: (\_\_\_\_) \_\_\_\_\_ CELL PHONE (\_\_\_\_) \_\_\_\_\_

E-MAIL ADDRESS(ES): \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

**OPTIONAL: If different from above or reverse side:**

OTHER PARENT/GUARDIAN'S NAME(S): \_\_\_\_\_

OTHER HOME ADDRESS: \_\_\_\_\_

HOME PHONE: (\_\_\_\_) \_\_\_\_\_ CELL PHONE (\_\_\_\_) \_\_\_\_\_

E-MAIL ADDRESS(ES): \_\_\_\_\_

**The other side of this form must be filled out and signed.**

**MEDICAL RELEASE FORM**

**St. Francis de Sales Seminary does not provide health or accident insurance for retreat participants. Parent/Guardian will be responsible for any medical treatment.**

PARTICIPANT'S NAME: \_\_\_\_\_ BIRTH DATE: \_\_\_\_\_ SEX: \_\_\_\_\_

FAMILY DOCTOR: \_\_\_\_\_ PHONE:(\_\_\_\_) \_\_\_\_\_

Family Health Plan Carrier: \_\_\_\_\_ Policy Number: \_\_\_\_\_

**MEDICAL MATTERS:** I hereby warrant to the best of my knowledge, my child is in good health, and I assume all responsibility for the health of my child. OF THE FOLLOWING STATEMENTS pertaining to medical matters. SIGN ONLY THOSE IN ACCORDANCE WITH YOUR WISHES.

**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: \_\_\_\_\_

HOME PHONE: (\_\_\_\_) \_\_\_\_\_ BUSINESS PHONE:(\_\_\_\_) \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Other Medical Treatment:** In the event it comes to the attention of DESIGNATED SUPERVISOR or staff that SON/WARD becomes ill with symptoms of headache, vomiting, sore throat, fever, or diarrhea, I DO want to be called.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Medications:** SON/WARD is taking medications at present and will bring the medication in the original container, **and only the number of doses necessary for the duration of this activity.** I give permission for SON/WARD to take this medication on his/her own. The dosage and frequency of dosage is as follows:

\_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Over-the counter medication:** Any over-the-counter medication, such as: aspirin, ibuprofen, Tylenol, cough drops, etc must come from home. No over-the-counter medications will be dispensed to SON/WARD.

**Specific Medical Information:** St. Francis de Sales Seminary will take reasonable care to see that the following information is held in confidence.

Allergic reactions (medications, foods, plants, insects, etc.): \_\_\_\_\_

Does child have a medically prescribed diet? \_\_\_\_\_

Any physical limitations or health concerns? \_\_\_\_\_