Official legal form for the Diocese of Salina

FORM C

Date ____________________

PARENTAL GUARDIAN MEDICAL CONSENT FORM AND LIABILITY WAIVER

This form is to be used for any parish, Catholic school, or diocesan field trips.

Diocese ____Salina________________ Parish ________________________ School ____________________

Destination __________________ ________________________________

Name of Participant (minor): ____

Home address: ____

Cell Number ________________ Home Phone Number ________________ Business Number ________________

MEDICAL MATTERS:

The Parish/School/Organization will take all reasonable and prudent care to see that confidentiality regarding the following information is maintained.

I/We hereby warrant that to the best of my/our knowledge, my/our child is in good health, and I/we assume all responsibility for the health of my/our child. I/We understand and acknowledge that any medical expenses related to illness or injury to my/our child are not covered by an insurance program maintained by the Parish/School/Organization or the Diocese of Salina, and that I/we am/are responsible for such expenses.

I/We understand that first aid will be available on the above mentioned trip. I/We further understand that should an accident, injury, or illness occur, medical and/or hospital care will be obtained. I/We realize the sponsors will make a reasonable effort to notify me/us in case of accident, injury, or illness; however, should they be unable to contact me/us, they have my/our permission to pursue a course of medical action which is in the best interest of the child.

I/We understand that a reasonable effort will be made to promptly notify me/us in the event of any serious illness or accident and prior to any major surgery, except when delay in such communication would endanger life. In case of medical emergency, in the event I/we cannot be reached, I/we hereby give permission to the physician or health care provider selected by the adult staff to hospitalize, secure proper treatment for, and order whatever injection, anesthesia, or surgery said physician or health care provider deems necessary for the child.

A doctor, clinic, hospital, or health care provider may proceed with any medical or surgical treatment that such sponsor may authorize.

I further understand that I will be responsible for all medical, surgical, and transportation costs which may be incurred.

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Signature: ________________________________ Date ________________________
Parent Or Guardian

Signature: ________________________________ Date ________________________
Parent Or Guardian

(over)

INSURANCE INFORMATION: **FORM C**

Insurance Company ** ______________________________ Policy No. _________________________

Policy Holder _________________________ Date of Birth ___________ Occupation _________________

Employer _______________________ Address ____

Employer's phone # _________________________

** If Blue Cross/Blue Shield Insurance please state if it is Blue Choice, Blue Select, etc.