



Holy Family Journeys Outing

PERMISSION & AUTHORIZATION FORM FOR MEDICAL TREATMENT

I/We, the parent(s) of _____ request that Holy Family Youth Ministry program allow my/our child to participate in

Event: overnight camping and caving trip

When: May 5-6 – leaving at 9A, returning about 5PM the following day.

Place: meet at Holy Family

Cost for this program is \$50. Includes camp equipment and all food except lunch on the 5th (bring a sack lunch).

I hereby release and indemnify Holy Family Parish, its staff and its volunteers and the Catholic Bishop of Chicago, a corporation sole, from any and all liability arising from claims of any kind or nature whatsoever from my child's participation in this event.

In the event that the undersigned or my (our) authorized physician, cannot be reached, and in the judgment of a responsible person accompanying the group, or other appropriate staff member, there is a necessity for immediate examination and/or treatment of my (our) child, I/We hereby authorize any of the aforesaid people to obtain for my child such medical services as are deemed necessary.

Home Phone Number _____ Other number (if applicable) _____

Family Physician _____ Phone Number _____

Name of Insurance Co. _____ Policy Number _____

Person to contact in case of emergency (if unable to reach parent):

Name/Relationship

Phone Number

Parent(s) Name(s)

Specific medical allergies, chronic illnesses and other conditions. Please list any & all medications that your child may take during the trip: _____

Parent/Guardian Signature

Date