Middle School Shine Rally Permission Form **DUE: MARCH 9th, 2018**

Dear Parent or Legal Guardian: Your son/daughter is eligible to participate in a church-sponsored activity requiring transportation to a location away from the church property. This activity will take place under the guidance and supervision of employees from St. Patrick's Church. A brief description of the activity follows:

Name of Event: 6-8th grade Shine Rally **Student Cost:** $25
Date/Time Departure: Sat. March 24 approx 1:00 PM **Anticipated Time of Return:** 9:30 pm
Activity Supervisor: Teesie Fritsch **Transportation:** Volunteer Drivers or Bus
Destination: West Catholic H.S. Grand Rapids, MI

WHAT TO BRING: Please eat before you come, or bring a sack lunch to eat on the bus so you don't get hungry at the Shine Rally! Dinner will be served at this event. **Do not bring any valuables, iPods, etc. Students may bring cell phones, but must keep them off during the rally.**

(Please Keep Top of Form for Your Own Information)

If your child is able to participate in this event, please complete, sign, and return the following statement of consent and acknowledgement along with event fee before March 9th, 2018. As parent or legal guardian, you remain fully responsible for any legal responsibility which may result from any personal actions taken by the named student.

I hereby consent to participation by my child, _____, in the event described above. I understand that this event will take place away from the church grounds and that my child will be under the supervision of the designated church employee on the stated dates. I further consent to the conditions stated above on participation in this event, including the method of transportation.

_____ _____ _____
(Print Parent/Guardian Name) **(Parent/Guardian Signature)** **(Date)**

_____ _____ _____
(Emergency Contact) **(Relationship to Minor)** **(Phone #)**

E-Mail: _____

As a parent/guardian, I do hereby authorize the treatment by a qualified and licensed Medical Doctor in an emergency, which, in the opinion of the attending physician, may endanger his/her life, cause disfigurement, physical impairment, or undue discomfort if delayed. This authority is granted only after a reasonable effort has been made to reach me.

Name of Minor:_____ **DOB** _____
Relationship to you: _____ **Phone:** _____
Address of Minor: _____**City:** _____ **State:**_____ **Zip:** _____
Family Physician: _____ **Phone:** _____
Address: _____**City:** _____ **State:**_____ **Zip:** _____

List any allergies, medication, contacts, or other pertinent comments: _____

_____

_____

_____

Health Insurance Company:_____**Policy:**_____
Group:_____ **Contract:** _____

This release form is completed and signed of my own free will with the sole purpose of authorizing medical treatment under emergency circumstances in my absence.

Signed:_____ **Date:**_____
(Parent or Guardian)