ST. MAXIMILIAN KOLBE CATHOLIC CHURCH

5801 Kanan Road • Westlake Village, CA 91362 • (818) 991-3915 ext. 137

MaryAnn Heredia – Faith Formation Secretary – Mheredia@stmaxchurch.org

FAITH FORMATION VBCamp 2018
PERMISSION SLIP / MEDICAL RELEASE FORM

PARENT/GUARDIAN CONSENT FORM/WAIVER OF CLAIMS AND MEDICAL INFORMATION/AUTHORIZATION FOR PARTICIPATION IN EVENTS AND/OR ACTIVITIES SPONSORED BY ST. MAXIMILIAN KOLBE FAITH FORMATION AT ST. MAXIMILIAN KOLBE PARISH.

_____

PRINT LAST NAME, FIRST NAME

has my permission to participate in Faith Formation sponsored events and/or programs at St. Maximilian Kolbe Parish for the period from June 1, 2018 – August 31, 2018

I agree to direct my son/daughter to cooperate and to conform to the directions and instructions of the St. Maximilian Kolbe (SMK) Faith Formation personnel and volunteers in charge of activities, and I understand that transportation for my daughter/son to Faith Formation sponsored events will be provided by the Participant's respective Parent/Guardian.

I also give permission for my son/daughter to be photographed at Faith Formation activities and possibly be posted on the St. Max's Web Site, parish bulletin or on posters at St. Max's.

I, the undersigned, hereby release St. Maximilian Kolbe, agents, representatives from all liability arising out of or in connection with all St. Maximilian Kolbe Faith Formation activities. For the purpose of this agreement, liability means all claims, demands, losses, causes or action, suits or judgments of any and every kind that **I,** my heirs, executors, administrators or assignees may have against St. Maximilian Kolbe, or that any other person or entity may have against St. Maximilian Kolbe because of death, personal injury, or illness, or because of any loss or damage to property that occurs during any activities and that results from any other cause other than negligence.

Should it be necessary for my son/daughter to require medical testing and/or treatment while participating in events sponsored by St. Maximilian Kolbe Faith Formation in which I (Parent/Legal Guardian) cannot be contacted, permission is hereby given to SMK personnel and volunteers to render medical treatment deemed necessary and appropriate by the physician. I understand that any insurance benefits that are active have limited application.

I have read and understand the foregoing statements and agree to assume the responsibilities stated above.

Parent/Legal Guardian Signature:_____ Date:_____

Participant's Address:_____ City:_____ Zip:_____

Participant's Home Phone #:_____ Participant's D.O.B.:_____

Parent/Legal Guardian Work Phone or Cell#:_____

Emergency Contact Person (other than parent):_____

Emergency Contact's # (home):_____ (work/cell):_____

Family Physician:_____ Phone #:_____

Medical Group Coverage:_____ Group/Member Number:_____

*** Please be aware of the following medical condition(s) for my son/daughter listed here:**

Does your child have allergies? Yes_____ No____ If yes, please list_____