

# BrilliantMont



A Christian International School

## FIELD TRIP/OUTSIDE SCHOOL ACTIVITIES

### PARENTAL/GUARDIAN CONSENT FORM AND LIABILITY WAIVER

Participant's / Child's Name : \_\_\_\_\_ Birth Date : \_\_\_\_\_

Parents/Guardian's Name : \_\_\_\_\_

Home Address : \_\_\_\_\_

Home Phone : \_\_\_\_\_ Work Phone : \_\_\_\_\_

E-mail : \_\_\_\_\_

I, ( Parent/Guardian) \_\_\_\_\_, grant permission to my child, ( Child's Name ) \_\_\_\_\_, to participate in this activity/event that required transportation.

A brief description of the activity follows:

Type of event : \_\_\_\_\_

Location of event : \_\_\_\_\_

Date and time of departure : \_\_\_\_\_ Date of Return : \_\_\_\_\_

Mode of transportation to and from event : \_\_\_\_\_

As parent and/or legal guardian, I remain legally responsible to any personal action taken by the above named minor participant.

I agree on behalf of myself, my child named herein, or our heirs, successors and assigns, to hold harmless and defend the organizers, its officers, director, staff and agents, and any other representatives associated with the event, from any and all actions, claims, demands, damages, costs, expenses and all consequential damage arising from or in connection with my child attending the event or in connection with any illness or injury or cost of medical treatment in connection therewith, and I agree to

Parents/Guardian's Name: \_\_\_\_\_ Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**Medical Matters:**

I hereby warrant that to the best of my knowledge, my child is in good health, and I assume all responsibility for the health of my child.

**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 and you are unable to reach me at the above numbers, contact:

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone : \_\_\_\_\_

Family Doctor: \_\_\_\_\_ Phone : \_\_\_\_\_

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

**Specific Medical Information:** The Organizer will take reasonable care to see that the following information will be held in confidence:

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

Immunizations–Date of last tetanus/diphtheria immunization: \_\_\_\_\_

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

Any physical limitations? \_\_\_\_\_

Is child subject to chronic homesickness, emotional reactions to new situations, sleepwalking, bedwetting, fainting? \_\_\_\_\_

Has child recently been exposed to contagious disease or conditions, such as mumps, measles, chickenpox, etc.? If so, date and disease or condition: \_\_\_\_\_

You should be aware of these special medical conditions of my child: