

**HOLY CROSS PRIMARY SCHOOL PARENTAL/LEGAL GUARDIAN  
PERMISSION SLIP FOR FIELD TRIP PARTICIPATION**

Dear Parent or Legal Guardian:

Your son, guardianship, is eligible to participate in a school-sponsored activity at a location away from the school site. This activity will take place under the guidance and supervision of an employee(s) from Holy Cross School. A brief description of the activity follows:

**Curriculum Goal:** Exploratory Courses/School Masses

**Location:** Holy Cross School, 5500 Paris Ave, New Orleans, La

**Designated Supervisor of Activity:** Mrs. Teresa Billings and Mrs. Belinda Baker

**Dates:** August 15, 2016 – May 24, 2017

**Method of Transportation:** Holy Cross School Bus

If you would like your son to participate in this event, please complete, sign, and return the following statement of consent and release of liability.

My son, \_\_\_\_\_, has permission to attend this field trip.

As parent, and/or legal guardian, I remain legally responsible for any personal actions taken by the above named minor ("participate"). I agree on behalf of myself, my son named herein, or our heirs, successors, and assigns, to hold harmless and defend Holy Cross School, its officers, directors, employees and agents from any claim arising from or in connection with any illness or injury or cost of medical treatment in connection therewith, and I agree to compensate Holy Cross School, its employees and agents and chaperons, or representative associated with the event for reasonable attorney's fees and expenses which may incur in any action brought against them as a result of such injury or damage, unless such claim arises from the negligence of the school.

Signature of Guardian: \_\_\_\_\_ Date \_\_\_\_\_

**MEDICAL INFORMATION**

Emergency Medical Physician \_\_\_\_\_ Phone \_\_\_\_\_

Allergies: \_\_\_\_\_ Medication: \_\_\_\_\_

List medical or psychological conditions for your son: \_\_\_\_\_

Legal Alert \_\_\_\_\_

**AUTHORIZATION TO TREAT A MINOR**

I (we) authorize and consent to my son, a minor, receiving any x-ray examination, anesthetic, medical or surgical diagnosis or treatment supervision upon the advice of a licensed physician. It is understood that reasonable effort shall be made to contact the undersigned prior to rendering treatment, but that treatment will not be withheld if the undersigned cannot be reached.

Signature of Guardian: \_\_\_\_\_ Date \_\_\_\_\_

Please return this and all other associated forms by: **August 17, 2015**

In case of emergency I can be reached at: \_\_\_\_\_