

St. John the Baptist Catholic Church/School

Field Trip  
Parental/Guardian Consent Form and Indemnity Agreement

Participant's Name: \_\_\_\_\_ Sex:  Male  Female  
Birth Date: \_\_\_\_\_ E-Mail: \_\_\_\_\_  
Parent/Guardian's Name: \_\_\_\_\_ Grade \_\_\_\_\_  
Home Address: \_\_\_\_\_ City: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Business Phone: \_\_\_\_\_  
Cell Phone: \_\_\_\_\_

Date/Type of Event: **FEED MY STARVING CHILDREN ~ CIRCLE DATE BELOW:**  
**Nov. 18 (Eagan); Dec. 16 (Chanhassen); Feb. 10 (Chanhassen)**

Destination: **See Above**

Individual(s) In Charge: **Andi Little/Lori Taormina**

Estimated time of departure and return: **5:15 p.m. – 8 p.m.**

Mode of Transportation to and from event: **Carpool**

Student Cost if applicable: **no fee**

Special needs for event: **Meet in the Atrium & EAT BEFORE YOU COME**

I, \_\_\_\_\_, grant permission for my child, \_\_\_\_\_,  
(Parent or Guardian's Name) (Child's Name)

to participate in the above-named activity and I warrant that my child is in good health. In consideration of my child's participation, I agree to indemnify St. John the Baptist Catholic Church and/or School and the Archdiocese of St. Paul/Minneapolis from any claims or law suits brought against St. John the Baptist Catholic Church and/or School and the Archdiocese of St. Paul/ Minneapolis by myself, my child or others, that arises out of any behavior by my child at the event/activity described above. I also agree to pay reasonable attorney's fees or expenses incurred by St. John the Baptist Catholic Church and/or School and the Archdiocese in defense of such a claim/law suit.

Emergency medical treatment: In the event of an emergency, I hereby give permission to transport my child to a hospital for emergency medical treatment. I wish to be advised prior to any further treatment by a doctor or hospital. In the event of an emergency, if you are unable to reach me at the above numbers, contact:

\_\_\_\_\_  
(Name) (Phone)  
Optional medical Information:  
Medication my child is taking at present: \_\_\_\_\_  
Family Health Plan carrier number: \_\_\_\_\_  
Family Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

As parent or guardian, I agree to all of the above-stated considerations and conditions.

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

**I can Chaperone/Drive** \_\_\_\_\_ phone \_\_\_\_\_

I have completed St. John's background paperwork & completed VIRTUS Training. (If not, there are packets available in the Education office).