



Sacred Heart High School

Educating young women for the future since 1907

STUDENT AND YOUTH ACTIVITY PERMISSION FORM

STUDENT'S NAME: _____ GRADE: _____

Activity: ☐ Field Trip ☐ Other (specify) _____

Date: _____ Cost: _____

X

Educational Purpose: _____

Description of Activity: _____ ☐ See Attached

Mode of Transportation: ☐ Walk ☐ Car Pool ☐ Bus ☐ Other (specify) _____

Teacher/Adult Leader: _____ Attire: _____

I request that my son/daughter be permitted to participate in the above activity. My child has no medical condition that would render it inappropriate for him/her to participate in this activity. I have returned the Health and Medical Release Form to the school/parish. I agree to direct my child to cooperate and conform to directions and instructions of the parish, school or Archdiocesan personnel responsible for this activity.

As a condition of participating in this activity, I hereby release and discharge The Roman Catholic Archbishop of Los Angeles, a corporation sole, Archdiocese of Los Angeles Education & Welfare Corporation and the school and parish, their respective employees and any parent/volunteer chaperone, from any and all claims for personal injuries, wrongful death or property damage that my son/daughter may suffer as a result of participation in the activity described above, whether or not, such injuries or damage are caused by the negligence (active or passive) of the Archdiocese, the parish, the school or their employees or chaperones.

Should it be necessary for my son/daughter to have medical treatment while participating in this trip, I hereby give the responsible personnel or chaperones permission to use their judgment in obtaining medical service, and I give permission to the physician selected by the school personnel or chaperone to render medical treatment deemed necessary and appropriate by the physician. I agree to relieve the school and other participating adults from any liability in connection with this request.

I understand that the insurance benefits through the school or parish, if any, may have limited application, and that I am entirely responsible for the cost of all medical treatment provided to my child. I agree to indemnify and hold the school harmless from the cost of any medical treatment and related expense and cost incurred.

Parent/Guardian

Date

Home Phone

Cell Phone

Work Phone

Person to Notify in case of Emergency if Parent or Guardian is unavailable:

Name: _____

Day phone: _____

Cell: _____

**ARCHDIOCESE OF LOS ANGELES
MEDICATION AUTHORIZATION AND PERMISSION FORM**

Part A, B & C to be completed by a licensed Physician
Part D by parent/guardian - *please print*

A. _____
Last Name of Student First Name Sex Birth Date

Purpose of Medication or Diagnosis Name of Medication

Dosage Prescribed Time Schedule at School Dose Form(tablet/liquid) Color

Date of Prescription Length of Time this Medication will be Necessary

B. Physician's Recommendations. (check where applicable)

_____ Please notify this office if patient misses medication at school.

_____ Medication may have adverse effects (explain) _____

_____ Special instructions and/or comments _____

C. Physician's Authorization. The student for whom this medication is prescribed is under my care.

Print Name of Licensed Physician Signature of Licensed Physician

Address Telephone Date

D. Permission for Medication to be Taken During School Hours

I request that my child, _____, be permitted to receive and to be assisted/supervised in taking the above prescribed medication at school. I will comply with the policies and procedures determined by the school district.

Date Day Telephone Emergency Telephone

Signature of Parent/Guardian