PARENT/LEGAL GUARDIAN PERMISSION SLIP AND INDEMNITY AGREEMENT

MUST BE RETURNED BY: Nov. 15, 2024

Name of Child/Ward: _____

Parish/School: Holy Trinity Catholic School

Designated Supervisor of Activity: Mrs. Hines & Mr. Hugo

Activity: Delivery of Operation Christmas Child Shoeboxes to North Strand Community Church, 2582 Mt Zion Rd, Little River, SC

Description of Activity: Social Outreach

Date(s) of Activity: 11/22/24

Time leaving school: 8:30a **Time returning to school: approx. 9:15a**

Activity Fee: $0

Lunch: N/A

Other Notes:

Uniform/Clothing:

Transportation: School Bus X **Contracted Bus** ☐ **Parent Cars** ☐ **Walk** ☐

I consent to the participation of my CHILD/WARD in the above named ACTIVITY. In consideration for my CHILD/WARD's participation, I agree to reimburse and indemnify the PARISH/SCHOOL (understood to include Bishop of Charleston A Corporation Sole) for all reasonable legal and court fees incurred by PARISH/SCHOOL in defending a lawsuit that I or my CHILD/WARD may bring against the PARISH/SCHOOL which relates to the above named activity if the PARISH/SCHOOL is found not legally liable by the courts and prevails in the lawsuit. If the PARISH/SCHOOL is found legally liable for injuries sustained by CHILD/WARD, this paragraph will not apply.

I certify that I have an understanding of this agreement and any risks and hazards associated with the ACTIVITY described above that my CHILD/WARD will be participating in. I further understand that I had the opportunity to fully discuss this agreement with a representative of the PARISH/SCHOOL to clarify any concerns or questions about the ACTIVITY or this agreement that I may have had.

_____ _____

Parent/Legal Guardian Signature **Date**

Phone numbers: Home ( ) _____ Work ( ) _____

Address:

_____

EMERGENCY INFORMATION

This information accompanies the teacher. Please be sure it is <u>complete and accurate</u> for this date.

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

Name: _____ **Phone Number:** _____

Name: _____ **Phone Number:** _____

Please furnish medical information about your CHILD/WARD which may be pertinent to his/her participation in the above identified ACTIVITY:

_____

_____

The information provided above is correct to the best of my knowledge.

_____ _____

Parent/Legal Guardian Signature **Date**

Phone numbers: Home ( ) _____ Work ( ) _____

Address:

_____

VOLUNTEERS

I CAN DRIVE AND HELP CHAPERONE ☐ **YES** ☐ **NO**

- **If yes the following must be on file in the school office:**
  - **Adult Hold Harmless/Indemnity Agreement**
  - **Driver Information Form Transportation Policy**
  - **VIRTUS certificate**
  - **Acceptable Diocesan Screening report**
- **Number of students with seat belts (no airbags) I can transport; _____**

I CAN HELP CHAPERONE ONLY : ☐ **YES** ☐ **NO**

- **If yes the following must be on file in the School Office.**
  - **Adult Hold Harmless/Indemnity Agreement form**
  - **VIRTUS certificate**
  - **Acceptable Diocesan Screening report**