

**SAINT JOHN THE EVANGELIST SCHOOL**  
2621 McMenemy Street  
Little Canada, MN 55117  
(T) 651/484-3038, (F) 651/481-1355

**FIELD TRIP CONSENT FORM AND INDEMNITY AGREEMENT**

Participant's Name: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Sex: \_\_\_\_\_

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

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

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

Date: _____	Event/Activity: _____
Destination: _____	
Individual(s) in charge: _____	
Estimated time of departure: _____ <b>and</b> time of return: _____	
Mode of transportation to <b>and</b> from event: _____	
Student Cost (\$): _____	

- \_\_\_\_\_ Chaperones are **NOT** needed for this event.
- \_\_\_\_\_ Chaperones **ARE** needed for this event.  
(*PLEASE check closely with teachers as to appropriate student behavior for this event.*)
- \_\_\_\_\_ I would like to volunteer to chaperone this event. Chaperone Cost (\$): \_\_\_\_\_
- \_\_\_\_\_ This event is **NOT** appropriate for pre-school age children.

I, \_\_\_\_\_, grant permission for \_\_\_\_\_  
(Parent/Guardian's Name) (Child's Name)

to participate in the above named activity and I warrant that my child is in good health. I agree to indemnify the parish/school and the Archdiocese of St. Paul/Minneapolis from any claims for law suits brought against the parish/school/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 the parish/school and the Archdiocese in defense of such a claim/law suit.

**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 a doctor or hospital. In the event of an emergency, if you are unable to reach me at the above numbers, please contact:

\_\_\_\_\_  
(Name) (Phone Number)

**OPTIONAL MEDICAL TREATMENT:**

Medication my child is taking at present: \_\_\_\_\_  
\_\_\_\_\_ Medication should be sent with the teacher to be given to my child at the prescribed time.

Family Health Plan – Carrier Number: \_\_\_\_\_

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

Parent Signature: \_\_\_\_\_