PERMISSION SLIP FOR OFF CAMPUS TRIP OR ACTIVITY

We request that (please print student's name) ______________________________ be allowed to attend the off campus trip or activity on __________________ to ___________________________ departing at _______________ and returning __________________. We understand that all rules of conduct and standard of behavior, as deemed by Quincy Notre Dame High School, will apply to this activity and have been discussed with our child. We further understand that we as parents/guardians must assume all responsibility and liability for our child while traveling to, from, and during the trip. The signature below indicates that we will assume that responsibility and liability.

Date: _________________________ Parent/Stepparent/Guardian Signature: ___________________________________

RELEASE OF ALL CLAIMS

In consideration of the permission granted to my child by Quincy Notre Dame High School, Quincy, Illinois to participate in this activity, I hereby release and discharge Quincy Notre Dame High School, its agents, employees, and officers from all claims, demands, and actions which the undersigned ever had, or now has, or may have, or which the undersigned's heirs, executors, administrators, or assigns may have, or claim to have against QND High School for all personal injuries, known or unknown, and injuries to property caused by, or arising out of, the above-described activity. I further acknowledge that I have adequate medical insurance to cover any medical costs relating to injury or accident arising from participation in the above activity.

I, the undersigned, have read this release and understand all of its terms. I execute it voluntarily and with full knowledge of its significance.

Date: _________________________ Parent/Stepparent/Guardian Signature: ___________________________________

AUTHORIZATION FOR MEDICAL TREATMENT

In case of injury to my child, permission is hereby granted to the attending physician to proceed with any medical or minor surgical treatment, x-ray, examinations, and immunizations. In the event of serious illness, the need for major surgery, or significant accidental injury, I understand that an attempt will be made by the attending physician to contact me in the most expeditious way possible. If said physician is not able to communicate with me, I hereby authorize the treatment necessary for the best interest of my child.

Date: _________________________ Parent/Stepparent/Guardian Signature: ___________________________________

PLEASE COMPLETE FOLLOWING INFORMATION:

Student's Name: ____ Home Phone Number: _________________

Address: ____ Cell Phone Number: ___________________

In Case of Emergency Contact: __________________________________ Work Number: _______________________

Cell Phone Number: ________________ Home Number: ______________________

Family Doctor: ____ Phone Number: ______________________

Family Dentist: ____ Phone Number: ______________________

List Any Medical Problems/Medicines/Allergies: ____

____

Name of Family Insurance Company ____

Policy Number: ____ Do You Have School Insurance? Yes _____No _____