STUDENT NAME: _____ STUDENT GRADE: _____

St. Louis King of France Catholic School
1609 Carrollton Ave., Metairie, LA 70005 ● (504) 833-8224 ● slkfschool.com
Rev. Colm J. Cahill, Pastor Shannon Culotta, Principal

2026-2027 FIELD TRIP PERMISSION FORM

PARENTAL/GUARDIAN CONSENT FORM & LIABILITY WAIVER

PARTICIPANT INFORMATION

Participant's Name: _____

Birth Date: _____ Sex: _____

Parent/Guardian's Name: _____

Home Address: _____

Home Phone: _____ Cell Phone: _____

I, _____, grant permission for my child,_____, to participate in _____ that requires transportation to a location away from the parish/school site. This activity will take place under the guidance and direction of employees and/or volunteers from St. Louis King of France. A brief description of the activity follows:

EVENT INFORMATION

Curriculum Goal: Exploratory Courses/School Activities/Hands-On Lessons to Reinforce In-Class Lessons
Location: In and around the metropolitan area (Specific details of locations, dates, and times will be sent as each individual activity is scheduled)
Designated Supervisor of Activity: SLKF Faculty and Staff
Dates: August 1, 2026 – May 31, 2027
Method of Transportation: School bus or parent/guardian will be required to provide individual transportation (Specific details regarding transportation will be provided once activities are scheduled)

As parent and/or legal guardian, I remain legally responsible for any actions of the above-named minor ("participant"). I confirm that there are no necessary changes to the Medical Information Consent form for my child. If there are any necessary changes, I will complete another Medical Information Consent form.

I agree on behalf of myself, my child named herein, and my spouse, our heirs, successors, and assigns, to indemnify, hold harmless, and defend **the parish and/or school** and The Roman Catholic Church of the Archdiocese of New Orleans, their members, directors, officers, employees, agents and representatives associated with the event from any and all liability claims, loss or damage arising from or in connection with the negligent or intentional acts of my child or third parties.

_____ _____
Parent's Name (please print) Parent's Signature

_____
Date

STUDENT NAME: _____ STUDENT GRADE: _____

MEDICAL INFORMATION

Participant's name: _____

Date of birth: _____ Gender: _____

Parent/Guardian name(s): _____

Home address: _____

City, State, Zip: _____

Parent Cell Phone: _____ Parent Work Phone: _____

Parent E-mail:_____

As parent(s) and/or legal guardian, I remain legally responsible for any personal actions by the above-named minor ("participant").

AUTHORIZATION TO TREAT A MINOR

I authorize and consent to my child, a minor, receiving any x-ray examination, anesthetic, medical or surgical diagnosis or treatment supervision upon the advice of a licensed physician. It is understood that reasonable effort shall be made to contact the undersigned prior to rendering treatment, but that treatment will not be withheld if the undersigned cannot be reached.

Signature of Parent/Guardian: _____

Date: _____ In case of emergency, I can be reached at: _____

SECTION I: MEDICAL MATTERS

As the parent/legal guardian of the above-named child, who is currently associated with St. Louis King of France, I hereby authorize **CYO/Youth & Young Adult Ministry Office, the Parish, and/or the School** or their assistants to carry out the authorizations I have delineated in areas of emergency medical treatment and other cases of illness. These authorizations inclusively extend from **August 1, 2026 through May 31, 2027**. I hereby warrant that, to the best of my knowledge, my child is in good health, and I assume all responsibility for the health of my child. I agree on behalf of myself, my child named herein, and my spouse, our heirs, successors, and assigns, to indemnify, hold harmless, and defend the CYO/Youth & Adult Ministry Office, the Parish, and/or the School, and The Roman Catholic Church of the Archdiocese of New Orleans, their members, directors, officers, employees, agents, and representatives from or in connection with any and all liability and/or damages (including but not limited to physical, mental, emotional and/or economic damages) that may be sustained arising from negligence, fault, or strict liability related to facilitating or administering the medical treatment agreed to herein.

Signature: _____ Date: _____

STUDENT NAME: _____ STUDENT GRADE: _____

SECTION II: EMERGENCY MEDICAL TREATMENT

In the event of an emergency, I hereby give permission to transport my child to a hospital for emergency medical or surgical 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 numbers listed herein, please contact:

Contact Name & Relationship: _____

Phone: _____

Family Doctor: _____ Phone: _____

Family Health Plan Carrier: _____ Policy #: _____

Signature: _____ Date: _____

SECTION III: OTHER MEDICAL TREATMENT

(OPTIONAL. SIGN ONLY IF YOU WANT TO BE NOTIFIED IN THE FOLLOWING INSTANCES)

In the event it comes to the attention of the CYO, the parish, the school, or their agents or representatives that my child becomes ill with symptoms such as headache, vomiting, sore throat, fever, diarrhea, I want to be called.

Signature: _____ Date: _____

SECTION IV: MEDICATIONS (SIGN ONLY THOSE OPTIONS THAT ARE APPLICABLE)

- **OPTION 1**: My child is taking medication at present. My child will bring all such medications necessary, and such medications will be well-labeled. Names of medications and concise directions for seeing that the child takes such medications, including dosage and frequency of dosage, are as follows:

  _____

  _____

  Signature: _____ Date: _____

- **OPTION 2**: I hereby grant permission for non-prescription medication (such as aspirin, throat lozenges, cough syrup) to be given to my child, if deemed appropriate.

  Signature: _____ Date: _____

- **OPTION 3**: NO medication of any type, whether prescription or non-prescription, may be administered to my child unless the situation is life-threatening and emergency treatment is required.

  Signature: _____ Date: _____

STUDENT NAME: _____ STUDENT GRADE: _____

SECTION V: SPECIFIC MEDICAL INFORMATION

The CYO or parish or school will take reasonable care to see that the following information will be held in confidence.

Allergic reactions (medications, foods, plants, insects, etc.): _____

Date of last tetanus/diphtheria immunization: _____

Does child have a medically prescribed diet? _____

Any physical limitations? _____

Is child subject to chronic homesickness, emotional reactions to new situations, sleepwalking, bed-wetting, fainting?

_____

Has child recently been exposed to any contagious disease or conditions, such as COVID-19, mumps, measles, chickenpox, etc.? _____

If so, date and disease or condition: _____

You should be aware of these special medical conditions of my child: _____

• You should be aware of these special medical and/or psychological conditions of my child:

_____

_____

• You should be aware of the following legal alerts pertaining to my child:

_____

_____

I, _____, understand that if any of the above information changes in any form it is my responsibility to update St. Louis King of France and complete a new form to have on file prior to any field trips scheduled between August 1, 2026 through May 31, 2027.

Signature: _____ Date: _____

Printed Name: _____ Relationship to Student: _____