STUDENT'S NAME: _____ STUDENT'S GRADE: _____

St. Louis King of France Catholic School

1609 Carrollton Avenue
Metairie, Louisiana 70005
Office: 504-833-8224 * Fax: 504-838-9938
www.slkfschool.com

Pamela K. Schott, Principal Reverend Mark Raphael, Ph.D., Pastor

My child, _____, is eligible to participate in school-sponsored activities at a location away from the school site. These activities will take place under the guidance and supervision of an employee(s) from St. Louis King of France School.

A brief description of the activities follows:

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, 2022 – May 31, 2023
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.)

If you would like your child to participate in scheduled field trips with their class, please complete, sign, and return the following statement of consent and release of liability, as well as provide all necessary information below.

I agree on behalf of myself, my child named herein, or our heirs, successors, and assigns, to hold harmless and defend St. Louis King of France Catholic School/Parish, its officers, directors, parishioners, and agents, and the Archdiocese of New Orleans, chaperones, or representatives associated with the event, arising from or in connection with my child attending the event or in connection with any illness or injury or cost of medical treatment in connection therewith, and I agree to compensate the parish, its officers, directors, parishioners, and the Archdiocese of New Orleans, chaperones, or representatives associated with the event for reasonable attorney's fees and expenses arising in connection therewith.

_____
Parent's Name (please print)

_____
Parent's Signature

_____
Date

STUDENT'S NAME: _____ STUDENT'S 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:_____

MEDICAL MATTERS: I hereby warrant, to the best of my knowledge, my child is in good health, and I assume all responsibility for the health of my child.

EMERGENCY MEDICAL TREATMENT: In the event of an emergency, I hereby give my 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 physician. In the event of an emergency, if you are not able to reach me at the above
numbers, contact:

Contact Name & Relationship: _____
Phone: _____

Family Doctor: _____ Phone: _____

Family Health Plan Carrier: _____ Policy #: _____

MEDICATIONS: 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 my child takes such medications, including dosage and frequency of dosage, are as follows:

_____
_____

Signature: _____ Date: _____

STUDENT'S NAME: _____ STUDENT'S GRADE: _____

□ 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: _____

□ I hereby grant permission for non-prescription medication (such as non-aspirin products, i.e. acetaminophen or ibuprofen, throat lozenges, cough syrup) to be given to my child, if deemed appropriate.

Signature: _____ Date: _____

SPECIFIC MEDICAL INFORMATION: The parish will take reasonable care to see that the following information will be held in confidence.

• Known Allergies (medications, foods, plants, insects, etc.):
_____
• Immunizations: Date of last tetanus/diphtheria immunization: _____
• Does child have a medically prescribed diet? _____
If yes, please explain: _____
_____
• Any physical limitations? _____
If yes, please explain: _____
_____
• Is child subject to chromic homesickness, emotional reactions to new situations, sleepwalking, bedwetting, fainting? _____
• Has child recently been exposed to contagious disease or conditions, such as mumps, measles, chicken pox, etc.? If so, list date and disease or condition: _____
If yes, please list the specific disease/condition and dates of exposure/treatment:
_____
_____
• 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, 2022 through May 31, 2023.

Signature: _____ Date: _____