



HOLY FAMILY CATHOLIC SCHOOL

Diocese of Orlando Field Trip Release Form

Event: _____

Date: _____ Organization Sponsoring Event: Holy Family Catholic School

Anticipated Departure Time: _____ Anticipated Return Time: _____

Name of Student: _____ Grade: _____
PLEASE PRINT

The undersigned, who is the parent/legal guardian of _____, a minor (hereinafter referred to as "Student"), on behalf of himself and Student, their personal representatives, assigns, heirs and next of kin, request Student be permitted to participate in the aforementioned event,

1. Hereby releases, waives, discharges and covenants not to sue _____ (Sponsor), their officers, employees and agents, all for purposes herein referred to as Releases, from all liability to the undersigned and Student, their personal representatives, assigns heirs and next of kin, for all loss or damage, and/or claims, demands, causes of actions or suites of any kind therefore, particularly on account of injury to the person or property or resulting in the death of Student, whether caused by the negligence of Releases or otherwise, while Student is a participant in the aforementioned event;
2. Hereby agrees to indemnify and save and hold harmless the Releases and each of them from any loss, liability, damage, or cost they may incur while Student is a participant in the aforementioned event, whether caused by the negligence of the Releases or otherwise;
3. Hereby assumes full responsibility for and risk of bodily injury, death or property damage due to the negligence of Releases or otherwise while Student is a participant in the aforementioned event;
4. Hereby agrees that if any portion of the Agreement is held invalid, that the balance shall, notwithstanding, continue in full legal force and effect.

SIGNATURE OF PARENT/LEGAL GUARDIAN

Date: _____

MEDICAL INFORMATION

In the event Student becomes ill, I authorize the directors or chaperones to obtain medical attention at a physician's office or hospital. Student is covered by the following medical insurance:

Insurance Company Name: _____ Group #: _____

Allergies: _____ Chronic/Acute Illnesses: _____

I UNDERSTAND THAT EVERY EFFORT WILL BE MADE TO REACH ME BEFORE MEDICAL PERMISSION IS GIVEN TO TREAT MY CHILD. HOME TELEPHONE () _____ - _____