**AMERICAN MARTYRS CHURCH**

**JR HIGH FUN NIGHT**

**EVENT PERMISSION SLIP**

This permission slip form is valid ONLY for the event listed below. The named minor must also have a Medical Release Form on file with American Martyrs Church SRE office (note this is DIFFERENT than the form submitted to American Martyrs School). If the minor does not have BOTH the Permission Slip and the Medical Release, he/she will not be allowed to attend the listed event/activity. Thank you for your cooperation! For any questions and/or concerns, please contact Kelly Champion or Denise Padden in the SRE Office (310) 546-4734.

PLEASE PRINT ALL INFORMATION:

Name of Minor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Activity/Event Location: **Not So Scary Movie Night. Saint Kateri Room**

Date of Event: **Friday, October 28, 2016** Time of Event: **6:45pm – 9pm**

Means of transportation (if applicable\*):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*\*Children must be released to a parent*

I, the legal guardian of the above named minor, request that he/she be permitted to participate in the sponsored by American Martyrs Church. I agree to direct the minor to cooperate and conform with the directions and instructions of the parish/school personnel responsible for the event. I agree that in the event the minor is injured as a result of his/her participation in the event, including transportation to and from these activities whether or not caused by the negligence (active or passive) of the parish youth activity program, or any of its agents or employees, recourse for the payment of any resulting hospital, medical or related costs and expenses will first be had against any hospital or medical insurance, or any available benefit plan of mine or of my spouse. I am not aware of any medical condition of my child which would render the event(s) inappropriate for him/her to participate in. I hereby give permission to the physician selected by the youth activities supervisory personnel then present, to render medical treatment deemed necessary and appropriate by the physician.

Parent/Legal Guardian Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please print name of above Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Cell Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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