St Rose of Lima School
200 Brentwood Ave
Warwick, RI 02886

BASKETBALL PERMISSION SLIP

MEDICAL INFORMATION AND PARENT/GUARDIAN CONSENT FORM/LIABILITY WAIVER

Participant's name: _____

Date of birth: _____ Sex: _____

Parent/Guardian's name:_____

Home address: _____

Cell phone: _____

I, _____ grant permission for my child, _____ to participate in this parish/school event that requires transportation to a location away from the parish/school site. This activity will take place under the direction and guidance of parish/school employees and/or volunteers from **St. Rose of Lima School**

Description of the activity:

Event: **Basketball (not a CAL run program)**
Date of event: **Saturdays, 11/6, 11/13, 11/20, 12/4, 12/11 & ? 12/18**
Destination of Event : **St. Rose of Lima School Gym**
Individual in charge:**John Bailey**
Time of Practices: **Grades 1 & 2:** 9 a.m. - 10 a.m **Grades 3 & 4: 10a.m. - 11 a.m.**
Mode of transportation:**Parent Drop off & Pick up**

As parent/guardian I remain legally responsible for any personal actions taken by the above named minor ('participant").

I agree on behalf of myself, my child named herein, or our heirs, successors, and assigns to hold harmless and defend St. Rose of Lima Parish/School its officers, directors, employees and agents, and the Diocese of Providence, its employees and agents, chaperones, or representatives associated with the event, from any claim arising from or in connection with my child attending the event or in connection with any illness or injury (including death) or cost of medical treatment in connection therewith, and I agree to compensate the parish/school, its officers, directors and agents, and the Diocese of Providence, its employees and agents and chaperones, or representatives associated with the event for reasonable attorney's fees and expenses which may incur in any action brought against them as a result of such injury or damage, unless such claim arises from the negligence of the parish/school or the Diocese of Providence.

Signature: _____ Date: _____

Masks must be worn as well as sneakers & appropriate gym attire for a Christian environment.Please bring a water bottle. Please remember if your child is ill/showing any signs of COVID please keep them home.

If interested please email Mr. Bailey @ johnbailey60@gmail.com

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Medical Matters:
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. (Of the following statements pertaining to medical matters, sign only those that are applicable.)

Emergency Medical Treatment: In the event of an emergency, I hereby give permission to transport my child to a hospital for 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 above numbers, contact:

Name & relationship: _____
Phone:_____ Family doctor:_____ Phone: _____
Family Health Plan Carrier: _____ Policy #: _____
Signature: _____ Date: _____

Other Medical Treatment: In the event it comes to the attention of the parish/school, its officers, directors and agents, and the Diocese of Providence, chaperones or representatives associated with the activity, that my child becomes ill with symptoms such as headache, vomiting, sore throat, fever, diarrhea, I want to be called collect (with phone charges reversed to myself).
Signature: _____ Date: _____

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 the medications and concise directions for seeing that the child takes such medication, including dosage and frequency of dosage are as follows:

_____
Signature: _____ Date: _____

NO medication of any type, whether prescription or nonprescription, 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 (ie, non-aspirin products such as ibuprofen or acetaminophen, throat lozenges, cough syrup) to be administered if deemed appropriate.
Signature: _____ Date: _____

Specific Medical Information: the parish/school will take reasonable care to see that the following information will be held in confidence;
Allergic reactions (medication, foods, plants, insects, etc) _____
Date of last tetanus/diphtheria immunization _____
Does child have a medically prescribed diet? _____
Does child have any physical limitations? _____

Is child subject to chronic homesickness, emotional reaction to new situations, fainting, sleep walking or bed wetting?
_____

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

Has the child recently been exposed to contagious disease or condition? _____

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