**MOUNT CARMEL ACADEMY OUT-OF-SCHOOL ACTIVITY PERMISSION FORM**

Group or Club Name: Soccer Summer Camp

Type of Activity: Soccer Camp

Location (facility name, address, and telephone number):

FROM: **Pan Am Stadium,** New Orleans City Park, New Orleans, LA 70124

TO: Mount Carmel Academy, 7027 Milne Blvd., New Orleans, LA 70124

Date of Activity: **June 4 to June 8, 2018**

Departure Time: 12:00 PM Return Time: 12:15 PM

Teacher(s) in Charge of Activity Pavlos Petrou (Soccer Coach)

Number of Students Participating**: TBA**

Describe the Educational Purpose of this Activity: Students will learn soccer techniques that contribute to a healthy lifestyle.

Date: Feb. 20, 2017 President/Vice-President’s Signature:

**THIS SECTION TO BE COMPLETED BY A PARENT OR LEGAL GUARDIAN**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, the parent/guardian of ,

request that Mount Carmel Academy allow my child/ward to participate in the activity described above.

**TERMS & CONDITIONS OF PARTICIPATION:**

Violations of civil law, use of alcohol or drugs, and other serious infractions of Mount Carmel Academy’s rules may result in my child/ward being dismissed from this activity. In the event of dismissal, I agree that it is my responsibility to arrange for my child’s/ward’s transportation home and to assume all costs related to her travel.

**MODE OF TRANSPORTATION**: (All Drivers must submit Use of Personal Vehicle Form, Drivers License, and Insurance Card.)

🞎 My daughter will provide her own transportation. (Passengers allowed: *proof of insurance required*)

🞎 My daughter will provide her own transportation. (No passengers allowed)

🞎 My daughter will ride with me, the undersigned.

🞎 My daughter will ride with \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ another student or parent, to and from this event.

🞎 Other **\_\_\_\_\_My daughter will ride in a school vehicle.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Comments: Students may be transported back to campus due to inclement weather as determined by the coach.

**RELINQUISHMENT OF CLAIMS:**

To the fullest extent allowed by law, I/We recognize and acknowledge that there are risks in my child’s/ ward’s presence and participation in the school sponsored program. I agree to indemnify, hold harmless, waive and relinquish any and all claims I may have against the Mount Carmel Academy and its officers, agents, employees, representatives or volunteers (heretofore, School) arising out of, in connection with the transportation to and/or from the event, or any activity my child/ward participates in while attending the school sponsored program, except for claims arising out of the sole or gross negligence and willful and wanton misconduct of the School its employees and representatives.

**MEDICAL RELEASE:**

Our permission is hereby given to the school representative of School to authorize, by his/her signature, whatever medical or surgical treatment may be considered necessary or advisable by the physician or nurse in attendance in the event of an accident or medical emergency involving:

STUDENT’S NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PARENT/GUARDIAN (Name Typed or Printed): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact Telephone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Parent or Guardian)

(**Attached is a copy of my child/ward’s current health benefit medical card)**

Company Name and type of Plan: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Individual to contact in case of emergency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Name) (Telephone)

FAMILY PHYSICIAN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_PHONE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_CITY:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ALLERGIES, REACTIONS OR OTHER COMMENTS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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