San Gabriel Mission High School

254 So. Santa Anita Street San Gabriel, CA 91776

Phone: 626/282-3181 **Fax:** 626/282-4209

WCEA/WASC Accredited www.sgmhs.org

DUE WEDNESDAY SEPTEMBER 28th To Room 123

STUDENT AND YOUTH ACTIVITY PERMISSION FORM

STUDENT NAME: _____ GRADE: **10th**

Activity: COLLEGE VISIT

Loyola Marymount University
1 LMU Drive
Los Angeles, CA 90045

Date: **FRIDAY, SEPTEMBER 30th**

Educational Purpose: **College Awareness**

Description of Activity: **Campus Visit**

Mode of Transportation: **Bus** Time: **8:00 am – 1:30 pm**

Teacher/Adult Leader: **Sallo/Tran-Trieu** Attire: **MISSION ATTIRE**

I request that my daughter be permitted to participate in the above activity. My child has no medical condition that would render it inappropriate for her to participate in this activity. I have returned the Health and Medical Release Form to the school. I agree to direct my child to cooperate and conform to directions and instructions of the parish, school or Archdiocesan personnel responsible for this activity.

As a condition of participating in this activity, I hereby release and discharge The Roman Catholic Archbishop of Los Angeles, a corporation sole, Archdiocese of Los Angeles Education & Welfare Corporation and the school and parish, their respective employees and any parent/volunteer chaperone, from any and all claims for personal injuries, wrongful death or property damage that my son/daughter may suffer as a result of participation in the activity described above, whether or not such injuries or damage are caused by the negligence (active or passive) of the Archdiocese, the parish, the school or their employees or chaperones.

Should it be necessary for my daughter to have medical treatment while participating in this trip, I hereby give the responsible personnel or chaperones permission to use their judgment in obtaining medical service, and I give permission to the physician selected by the school personnel or chaperone to render medical treatment deemed necessary and appropriate by the physician. I agree to relieve the school and other participating adults from any liability in connection with this request.

I understand that the insurance benefits through the school or parish, if any, may have limited application, and that I am entirely responsible for the cost of all medical treatment provided to my child. I agree to indemnify and hold the school harmless from the cost of any medical treatment and related expense and cost incurred.

_____ _____

Parent/Guardian Date

_____ _____ _____

Home Phone Cell Phone Work Phone

Person to Notify in case of Emergency if Parent or Guardian is unavailable:

Name _____ Relationship _____

Day phone: _____ Cell: _____