



St. Mary's Catholic Church & School

Faith. Scholarship. Leadership. Service.

Student Shadowing 2018-2019

To: The Parents of: _____

We are very happy to have your child(ren) visit our school to become acquainted with the other students and teachers.

In our love for your children and our concern for their safety, we need the following information:

Father: _____ Phone Number _____

Mother: _____ Phone Number _____

Address: _____ Phone Number _____

_____ Phone Number _____
Print Name of person who will be picking up your child(ren)

In the event of an emergency, print name and phone number of person we should contact

I realize that the school does not have to agree to allow my child(ren) to visit with a class. I understand that the school's agreeing to allow my child(ren) to visit is for my benefit and my child(ren)'s benefit. Such agreement by the school is adequate consideration of my agreements contained herein. In consideration for the school agreeing to allow my child(ren) to visit, I agree to indemnify and hold harmless the Diocese of Tyler, its servants, agents, and employees, including but not limited to the parish, the school, the principal and individuals from any and all claims, demands, or causes of action. I, on behalf of myself, any other parents/legal guardians of the child(ren), and the child(ren), hereby release and waive any and all claims, demands, or causes of action against the Diocese of Tyler, its agents, servants, or employees, including but not limited to the parish, the school, the principal and all other individuals at St. Mary's Catholic School.

Printed name of Parent/Legal Guardian Date

Signature of Parent/Legal Guardian Phone Number



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MEDICAL CONSENT TO TREAT 2018-2019

(This annual form is for general office use and is not event specific. A similar version of this form will be required for any out of town or overnight school trips for each specific event)

To the best of my knowledge, my child, _____, is in good health, and I assume all responsibility for the health of my child. In the event of an emergency, I give permission to transport my child to a hospital and seek emergency treatment. I wish to be contacted as soon as possible of any emergency care necessary.

General student information:

AGE: _____ HEIGHT: _____ WEIGHT: _____

PRIMARY CARE PHYSICIAN: _____ PHONE: _____

If you are unable to reach me, please contact:

Name Relationship to student Area Code & Phone

Insurance Carrier Policy Number Insurance ID Number

Please fill in the following as it pertains to your child:

My son/daughter is taking the following medications (list name of medication, dosage, frequency and any other important directions): _____

My son/daughter is up-to-date and current with their immunizations: ___ YES ___ NO

My son/daughter is allergic to the following: _____

My son/daughter has the following limitations or special needs: _____

Signature of Parent/Legal Guardian Date