

**Middle & High School Kings Dominion Trip**



**Date:** Friday, August 1<sup>st</sup> **Begins:** 9:00 am @ St. Mary's (with mass) **Return:** 9:00 pm  
**Cost:** \$35 \*. **Location:** Kings Dominion, VA **RSVP by:** July 24<sup>th</sup>

**Parents:** We would love help chaperoning and carpooling. Please contact the CYM Office if you are interested and able to help.

*\*If you are a season pass holder it will only cost you \$5 to help with gas.*

**Bring:** Sun screen, water bottle, spending money, bag to carry stuff in.

**Detach and retain this section for your information.**

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Detach and return this section with payment by the RSVP deadline of Thursday, July 24<sup>th</sup>.

**Middle & High School Kings Dominion Permission Slip**

\_\_\_\_\_ **If you have a Season Pass check here.**

As the parent/guardian of \_\_\_\_\_, I hereby give permission for my child to attend the Middle & High School Kings Dominion trip on Friday, August 1<sup>st</sup>.

I understand and acknowledge that participation in this activity involves inherent risks of injury to my child including risks associated with transportation by motor vehicle. I agree to indemnify the Parish, Youth Ministers, Volunteers, and the Diocese of Arlington for any costs or expenses arising out of my child's participation in this activity, including the cost of any medical care given my child or any expenses or fees incurred in any lawsuit arising as a result of any damage or injuries caused by my child in the course of his or her participation.

I further give my consent that in my absence the above-named minor be admitted to any hospital or medical facility for diagnosis and treatment. I request and authorize physicians, dentists, and staff, duly licensed as Doctors of Medicine or Doctors of Dentistry or other such licensed technicians or nurses, to perform any diagnostic procedures, treatment procedures, operative procedures and x-ray treatment of the above minor. I have not been given a guarantee as to the results of examination or treatment. I authorize the hospital or medical facility to dispose of any specimen or tissue taken from the above-named minor.

\_\_\_\_\_ Date of Birth \_\_\_\_\_ Grade \_\_\_\_\_ If a Vegetarian please specify here \_\_\_\_\_

\_\_\_\_\_ Allergies or medical conditions/concerns (Continue on back of form if needed)

\_\_\_\_\_ Name of Parent/Guardian \_\_\_\_\_ Parent e-mail address \_\_\_\_\_

\_\_\_\_\_ Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

\_\_\_\_\_ Phone: Home \_\_\_\_\_ Work \_\_\_\_\_ Mobile \_\_\_\_\_

\_\_\_\_\_ Person to notify if parent/guardian is unavailable \_\_\_\_\_

\_\_\_\_\_ Phone: Home \_\_\_\_\_ Work \_\_\_\_\_ Mobile \_\_\_\_\_

\_\_\_\_\_ Insurance Carrier & Policy Number \_\_\_\_\_ Family Physician Phone \_\_\_\_\_

\_\_\_\_\_ Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_