**St. Bernard’s Catholic Church**

**Parental/Guardian Consent Form**

**Event: Progressive Hayride, September 18, 2021**

**Grades 6th through 12th!**

**Chaperones Needed – Contact Misty Mehrkens at 681-3571 or misty.mehrkens@stbernardstrf.com**

Completed consent form must be returned to Misty Mehrkens **in order to participate.**

Participant Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Birthdate:\_\_\_\_\_\_Grade:\_\_\_\_\_\_\_\_\_

Parent/Guardian Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Parent Cell Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent Work Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

By signing this form I understand that as a parent/guardian, I remain legally responsible for any personal actions taken by the above named minor. I agree not to hold St. Bernard’s or the Diocese of Crookston responsible for any injury that may happen to my child. **Parent/Guardian Signature:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

By signing this consent form I fully understand that I am to follow all rules required by chaperone(s) and will refrain from using, possessing, purchasing, obtaining or distributing any drug, tobacco or alcohol products. I will dress modestly and refrain from inappropriate behavior and language. I will be a positive role model representing St. Bernard’s Parish.

**Student Signature:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In the event of an emergency, I hereby give permission to transport my child to a hospital for emergency medical or surgical treatment. I wish to be advised prior to any treatment by the hospital or doctor. In the event of an emergency, if you are unable to reach me at the above numbers, please contact the following:

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship:\_\_\_\_\_\_\_\_\_\_\_\_Phone Number:\_\_\_\_\_\_\_\_\_

Participant Medical Insurance Name and ID#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List all medical concerns and conditions to be aware of:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_