

**St. Joseph's Youth Ministry and Faith Formation**  
**Trick or Treat for Charity**  
**Grade 6-12**  
PARENTAL/GUARDIAN CONSENT FORM & LIABILITY WAIVER

Participant's Name: \_\_\_\_\_

Grade: \_\_\_\_\_ Sex: \_\_\_\_\_ School \_\_\_\_\_ Parent/Guardian's Name: \_\_\_\_\_

E-mail Address \_\_\_\_\_ Preferred Contact Phone # \_\_\_\_\_

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

I, \_\_\_\_\_, grant permission for my child, \_\_\_\_\_, to participate in the event, sponsored by St. Joseph. This activity will take place under the guidance and direction of parish employees and volunteers from St. Joseph.

<b>Type of event:</b>	<b>Trick or Treat for Charity</b>
<b>Location of the event:</b>	<b>St. Joe's Surrounding Neighborhoods –Meet in the Gathering Place</b>
<b>Individuals in charge:</b>	<b>Melissa Hund-Cerna (701-367-3345)</b>
<b>Date of event:</b>	<b>Wed. October 31 6:30-8:30 PM</b>
<b>Registrations due:</b>	<b>Wed. October 24.</b>
<b>Transportation:</b>	<b>Some youth will ride in vehicles of adult volunteers.</b>

As a parent and/or guardian, I remain legally responsible for any personal actions taken by the above named minor (participant). I agree on behalf of myself, my child named herein, or our heirs, successors, and assigns, to hold harmless and defend St. Joseph's, its officers, directors and agents, chaperones, or representatives associated with the event, arising from or in connection with my child attending the event or in connection with any illness or injury or cost of medical treatment in connection therewith, and I agree to compensate St. Joseph's, its officers, directors and agents, chaperones, or representatives associated with the event for reasonable attorney's fee and expenses arising in connection therewith.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

***We will meet in the Gathering Space at 6:30 PM. Registration will take place from 6:15-6:30 PM. Please try to be 10-15 minutes early. Youth are encouraged to wear their costume to be entered into the costume competition but costumes are not required. All youth will stay in groups and will have an adult driver follow them to collect canned food. Youth will be walking outside and should dress warmly. The event will conclude at 8:30 PM. This event is a competition between teams. Youth are encouraged to bring their own non-perishable food from home that will go towards their team's collection. All items will be donated to the Fill the Dome event. Youth are required to register beforehand and we will not be able to accept youth who show up the day of without a registration form for liability reasons. If you would like to volunteer to drive, please contact Melissa at 218-236-5066 or [mhundcerna@stjoesmhd.com](mailto:mhundcerna@stjoesmhd.com) All drivers must be 21+ and complete the Diocesan Safe Environment Training and Background check.***

*(Of the following statements pertaining to MEDICAL MATTERS, sign only those that are applicable.)*

**MEDICAL MATTERS**

I hereby warrant that to the best of my knowledge, my child is in good health, and I assume all responsibility for the health of my child.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**EMERGENCY MEDICAL TREATMENT:**

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 any emergency, if you are unable to reach me at the above numbers, contact:**

Name and Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_ Family Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

Family Health Plan Carrier: \_\_\_\_\_ Policy # \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**MEDICATIONS:**

My child is taking medication at present. My child will bring all such medications necessary, and such medications will be well-labeled. Names of medications and concise directions for seeing that the child takes such medications, including dosage and frequency of dosage, are as follows:

\_\_\_\_\_  
\_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**SPECIAL MEDICAL INFORMATION:**

St. Joseph will take reasonable care to see that the following information will be held in confidence. Allergic Reactions (medications, food, plants, insects, etc.):

\_\_\_\_\_  
\_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Immunizations: Date of last tetanus/diphtheria immunizations: \_\_\_\_\_

Any physical limitations? \_\_\_\_\_

You should be aware of these special medical conditions of my child: