

*Swimming at The Dive Shop Aquatic Center  
in Brookfield, Junior Youth Group  
March 13<sup>th</sup> from 6 – 8:30*

**Cost \$20.00, includes swimming rental and the bus.**

**Drop off 5:30 and Pick Up at 8:30 in the St. Rose parking lot. Locker rooms are available!**

**Please bring permission slips to the event or put in the mailbox located at the front door of the Parish Center. More information email at [jptaunton@sbcglobal.net](mailto:jptaunton@sbcglobal.net)**

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**Permission and Insurance Release for** (Child's name) \_\_\_\_\_.

Trip to, "Swimming ". \_\_\_\_\_ (Child's name) has my permission to participate in the St. Rose of Lima R. C. Church trip on March 13<sup>th</sup>, 2009 traveling with Joe DeMaida and other authorized chaperones.

I understand that neither St. Rose of Lima Church nor any of its agents are responsible for any injury sustained by my child. I accept responsibility for any medical expenses as a result of any such injury sustained.

\_\_\_\_\_  
(Phone Number)

\_\_\_\_\_  
(Parent or Guardian Signature)

\_\_\_\_\_  
(Date)

Please sign release form on the back of this permission slip.

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**For Medical Release Purpose**

To Whom it may Concern:

As a parent and/ or guardian, I do herewith authorize the treatment by a qualified and licensed medical doctor of the following minor in the event of a medical emergency which, in the opinion of the attending physician, may endanger his or her life, cause disfigurement, physical impairment or undue discomfort if delayed. This authority is granted only after a reasonable effort has been made to reach me.

This release is intended for March 13th, 2009. This form is completed and signed of my own free will with the sole purpose of authority medical treatment under emergency circumstances in my absence.

Signed \_\_\_\_\_  
(Father, Mother, Legal Guardian) (Date)

\_\_\_\_\_  
Address

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip

\_\_\_\_\_  
Home Phone

\_\_\_\_\_  
Work Phone

Family Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

\_\_\_\_\_  
Specific medical allergies, chronic illnesses or other conditions

Another person to contact in the case of emergency:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_