

**JOLIET DIOCESE VOCATION OFFICE  
ST. JOHN VIANNEY SEMINARY TRIP  
PARENTAL PERMISSION FORM**

PARENTAL / GUARDIAN AUTHORIZATIONS - Required of all participants

I hereby give permission for my child \_\_\_\_\_ to participate in the trip to St. John Vianney Seminary in St. Paul, MN from November 16-18, 2017, with the designated chaperone. Authorization and permission is hereby given to the diocese to furnish any necessary transportation, food and lodging for my child. I hereby release and indemnify the Vocation Office, its staff, volunteers, and the Joliet Diocese, from any and all liability arising from claims of any kind or nature whatsoever from my child's participation in this event.

I further agree to hold harmless and indemnify the Diocese of Joliet, its directors, employees and agents, for any liability sustained by the diocese as the result of the negligent, willful or intentional acts of my child, including expenses incurred attendant thereto.

Student Name \_\_\_\_\_  
Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_  
Year in School \_\_\_\_\_  
Email \_\_\_\_\_  
Signature of Parent/Guardian \_\_\_\_\_  
(\_\_\_\_) \_\_\_\_\_  
Area Code and Phone Number

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**MEDICAL PERMISSION FORM**

I grant permission for the administration of first aid to (Fill in the name of the child) \_\_\_\_\_ BY THE PEOPLE IN CHARGE OF THE ST. JOHN VIANNEY SEMINARY TRIP, and those transporting my child to and from the program as their judgement deems advisable, and to make the necessary referrals to qualified physicians for treatment of illness or accidents of a more serious nature. I understand that I will be promptly notified in the event of any serious illness or accident prior to any major surgery, except when delay in such communication would endanger life. In case of medical emergency, I understand that every effort will be made to contact the parents/guardian of the participant. In the event I cannot be reached, I hereby give permission to the physician selected by the adult staff to hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery, if deemed as necessary for my child.

Signature of Parent/Guardian \_\_\_\_\_ Email address \_\_\_\_\_

Date: \_\_\_\_\_ Address: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ City, State: \_\_\_\_\_

Any medication or medical condition that chaperones should be aware of: \_\_\_\_\_

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**INSURANCE INFORMATION**

Policy in name of: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Policy No.: \_\_\_\_\_

Send this completed form to the Vocations Office  
email to [Vocations@dioceseofjoliet.org](mailto:Vocations@dioceseofjoliet.org) or fax: 815-838-8129  
Mailing address: Blanchette Catholic Center, Vocations Office, 16555 Weber Road, Crest Hill, IL 60403