Visiting Student Permission Form
Mount Calvary Christian School
629 Holly Street
Elizabethtown, PA 17022
717/367-1649

Student's Name_____ Grade _____
(**Visiting Student)**

is invited to visit Mount Calvary Christian School (MCCS) as a guest of: _____
(Sponsoring Student)

Date of Visit:_____ Purpose of Visit_____

By their signature(s) below, the parents/guardians of the Visiting Student hereby acknowledge and give consent for their child to spend the above-referenced school day at MCCS for the purpose of experiencing a typical school day at MCCS. The Visiting Student will participate in all classes and activities of their sponsoring student, which may include physical education class, recess, lunch, etc. The Visiting Student will abide by all MCCS policies regarding behavior, dress code, etc. Pre-notification will be given to any/all affected staff members so that arrangements can be made for the Visiting Student to be accommodated.

Please provide the information requested below.

This release agreement does not apply to claims of intentional criminal misconduct or gross negligence by the school, its employees, or volunteers. If intentional or negligent conduct is proven in a court of law, I acknowledge and agree that I will hold harmless Mount Calvary Church and Mount Calvary Christian School, and all of its affiliated organizations, for any judgment or financial liability beyond the actual amount of liability insurance in force at the time of the occurrence.

In case of accident, illness, or other emergency, I request that the school contact _____ at this telephone number: _____
If the school cannot reach this person or other parent or guardian after conscientious effort, I give permission for school staff to call paramedics or any other health care provider. If a life-threatening emergency exists, I give permission for school staff to call paramedics immediately and then contact the person above as soon as possible thereafter. By the signing of this form, I authorize and consent to any X-ray examination, anesthetic, medical, dental, or surgical diagnosis or treatment and hospital care which in the best judgment of the health care provider is deemed advisable. I agree to assume the financial responsibility for expenses incurred as a result or those services being provided. I also agree to be financially responsible for emergency medical transportation and all other costs related or associated with medical treatment.

By signing below, I acknowledge that I have read and understand the rights and responsibilities described in this form. I further acknowledge that I agree to the terms listed above and that I intend to be legally bound by the terms of this document. (If the child lives with both parents, this release must be signed by both parents/guardians.)

<u>Parental Permission for Participation</u>

I have carefully read all the above information and understand its terms.
I give permission for my/our son/daughter to participate and agree to the terms for this MCCS visit.

_____ _____
Father/Guardians/ Signature and Date Mother/Guardian's Signature and Date

Name printed:_____ Name printed:_____

If the child lives with both parents, the release must be signed by both parents/guardians.

NOTICE: Please sign and return this form no later than 2 business days prior to visit.

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Please provide the information requested below: **(PLEASE PRINT)**

Physician: _____ Phone: _____

Dentist: _____ Phone: _____

Health insurance carrier: _____ Policy #: _____

Policy under the name of: _____ Relationship: _____

Allergies (including reactions to medication): _____

Medications being taken: _____

Preferred hospital: _____ Date of last tetanus: _____

What other physical or medical conditions should we know about? _____

Student's home phone: _____ Student's street and city: _____

Father's Employer: _____ Father's Work phone: _____

Cell phone: _____ Pager: _____

Mother's Employer: _____ Mother's Work phone: _____

Cell phone: _____ Pager: _____

In case of emergency, who should we contact if we are unable to contact the person listed above?

Name: _____ Relationship: _____ Phone: _____

Initial by the medications that you give permission for the school nurse to administer to your child only if determined to be needed.

_____ Tylenol
_____ Motrin/Ibuprofen
_____ Tums
_____ Neosporin Ointment
_____ Visine eye drops
_____ Cough Drops
_____ Benedryl (rash, poison ivy, stings)
_____ Anbesol
_____ Caladryl lotion (for poison ivy)
_____ Sudafed (MS/HS Only)

Signature _____

I prefer no medication be given to my child unless a parent can be reached.

Signature _____

I give permission for the school nurse to share any pertinent health information about my child to those teachers or faculty directly involved in his/her care.

Signature _____

APPROVALS

_____ Principal

_____ Superintendent

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