Household Program

Permission Form for Overnight Household   
Visitation of Siblings

The following permission form must be completed by the parents/guardians of a minor, for a sibling of a Household member who wishes to stay overnight in an SPO Household.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Guest Sibling:** | **Age:** | | **DOB:** | **M/F:** |
| **Sibling in SPO Household:** | | | **SPO Household:** | |
| **Arrival Date, Time:** | | **Departure Date, Time:** | | |
| **Parent/Legal Guardian:** | | | | |
| **Home Address:** | | | | |
| **City, State, Zip** | | | | |
| **Home Phone:** | | **Cell Phone:** | | |

On this \_\_\_\_\_\_\_\_\_\_ day of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, 20\_\_\_\_\_, I release from liability and indemnify and hold harmless Saint Paul’s Outreach, and any of its employees or agents representing or related to the organization as regards to the overnight Household visitation of siblings. This release is for any and all liability for personal injuries (including death) and property losses or damage occasioned by, or in connection with any activity or accommodations for this event. The guest sibling named above and below further agrees to abide by all the rules and regulations of Saint Paul’s Outreach and its Households, especially those articulated in **Household General Conduct Policy.**

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

### Name of Guest Sibling Name of Household Sibling

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

### Signature of Parent/Legal Guardian Date Signed

Household Program

Emergency Medical Release Form

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, give permission for my son/daughter, \_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, to visit the Saint Paul’s Outreach Household located at

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, where

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, the sibling of my son/daughter, resides. If needed for health reasons, I give permission for my child to be evaluated, diagnosed, treated, and/or given medication in accordance with the standard medical practice by licensed medical personnel. I relieve Saint Paul’s Outreach of all responsibility and consequences that may arise as a result of this treatment. I will not hold Saint Paul’s Outreach liable in the event of injury or death. Further, I agree to accept any and all financial responsibility as a result of scheduling medical treatment.

My son/daughter agrees to abide by all rules and regulations of Saint Paul’s Outreach Households, especially those articulated in the **Household General Conduct Policy**. I understand that while visiting the Household my son/daughter will be unchaperoned during his/her visit, in like manner as any Household resident. I understand that Saint Paul’s Outreach will not be liable if my child fails to cooperate with regulations, and that any infraction of the rules may result in immediate termination of their visit and all expenses in returning them home will be at my expense. I also agree to reimburse Saint Paul’s Outreach for any damage or liability suffered by Saint Paul’s Outreach as a result of my child’s actions or inactions.

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

### Parent/Guardian Signature Guest Sibling Signature

Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical History: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## In Case of Emergency, Please Contact:

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

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

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

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

Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_