ROMAN CATHOLIC
DIOCESE of ORANGE
PASTORAL CENTER DEPARTMENTOF CATHOLIC SCHOOLS

ROSARY ACADEMY

PARENT PERMISSION FORM for KNOTT'S BERRY FARM

The information below must be given to the appropriate teacher/advisor prior to the outing as designated by communication of the school.

ADVISOR: ***Nicola Huerta & Maggie LaBonte*** GROUP: ***Junior Class*** DESTINATION: ***Knott's Berry Farm***

DATE OF TRIP: ***Monday, September 14, 2026*** START TIME: ***9:00 am*** RETURN TIME: ***n/a*** MODE OF TRANSPORTATION: ***Self***

- Please complete and return this form and the Behavioral Contract to the Activities Office by **Monday, 08/10/2026**
- If your daughter is *not* attending Knott's, she MUST attend school on campus from 7:55am-2:05 pm.

Yes, I plan to go to Knott's Berry farm and will NOT be on campus on 9/08/2025. *Check One*:

___I would like to order a Knott's ticket for **$50.00**.

I am attaching the **$50.00** with payment in the form of: ____Cash; ____Check # _____

___I have a season pass and I will ***not*** be purchasing a ticket through Rosary.

I/we hereby request that_____Grade: 11___participate in the trip to Knott's
Student Name (please print)

I/we give my/our consent and understand that supervision and/or transportation for this event will be provided and that all diocesan and school policies will be strictly adhered to. I/we agree to direct my daughter to cooperate and conform with the directives and instructions of the supervisory personnel in charge of the activity.

STUDENT MEDICAL RELEASE

I/we, the parent(s)/guardian(s) of the above-named student, hereby, give my/our permission for her participation in the activity named above. I/we am/are not aware of any medical condition of my child which would render it inappropriate for her to participate in any such activity.

Should it be necessary for my/our child to have medical treatment (including dental or hospital treatment) on this trip, I/we hereby give the school personnel permission to use their best judgment in obtaining medical service for my child, and I/we give permission to the physician selected by the school personnel to render medical treatment deemed necessary and appropriate by the physician.

I/we agree that in the event my/our child is injured as a result of her participation in the above named activity, including transportation to and from such activity, whether or not caused by the negligence (active or passive) of the school or any of its agents or employees, recourse for the payment of any resulting hospital, medical, dental treatment or related costs and expenses will first be had against any accident, hospital, medical or dental insurance, or any available benefit plan of our family.

_____
Parent / Guardian Signature **Parent/Guardian Signature**

_____
Home Address **City** **Zip Code**

_____
(Home Phone Number) **(Cell Phone Number)** **(Work Phone Number)** **(Date Signed)**

Insurance Company:_____**Policy Number:** _____

Doctor's Name: _____**Phone Number:** _____

Allergies/Medical Problems / Disabilities: _____

Student Date of Birth:_____ **Age:** _____

Parents' Email Address(es): _____