

Authorization to treat minor: In the event that I, or other parent/guardian, cannot be reached in an emergency, I hereby give permission to the school staff to secure proper treatment for my child. I do hereby consent to whatever x-ray, examination, anesthetic, medical, surgical or dental diagnosis or treatment and hospital care are considered necessary in the best judgment of the attending physician, surgeon or dentist and performed by or under the supervision of the medical staff of the hospital or facility furnishing medical or dental services.

Parent/Guardian Section: MUST BE COMPLETED

Print Name(s) of Parent/Guardian: _____

Parent/Guardian Work Phone: _____

Parent/Guardian Work Phone: _____

Emergency Contact Person: _____

Emergency Phone Number: _____

Pagers, cell phones, e-mail: _____

Physician: _____ Phone: _____

Insurance Name: _____ Policy Number: _____

Student's Critical Medical Needs/Allergies/Conditions:

--

I acknowledge that I have carefully read this document and understand the information therein. I agree to each of the terms and acknowledgments above, and agree to permit my child to participate in the trip described above.

Date: _____ Parent/Guardian Signature: _____

Chaperones: If agreement has been reached with the supervising teacher, and I chaperone students on this trip, I will comply with all District requirements pertaining to the chaperoning of students.

Print Name

Signature