Code: **IIC/IICA-AR(3)**
Revised/Reviewed: 9/12
Orig. Code(s): IIC/IICA-AR

Parent Permission for Extended and /or Overnight Student Travel Slip

Student Name: _____ Grade: _____

Has permission to go on a school trip to: _____

With (school name): _____ On the following dates: _____

Teachers responsible are: _____

I understand my child will be transported in _____.

It is my understanding that the trip will be fully chaperoned and that the student will adhere to all of the rules of the organization, the school, and the Centennial School District, and be responsible to the school for all of his/her actions on the trip.

The above student is covered for accidental and medical insurance benefits:

_____ _____
Insurance Company Policy Number

Student's DOB: _____ City & State of Birth: _____

Allergies to foods, medications, bee stings, etc. (if none, so state): _____

Special medical problems (if none, so state): _____

Does participant carry medication on person? (if none, so state): _____

Date if last tetanus shot: _____

Medication: _____ Purpose: _____

Medication: _____ Purpose: _____

Family physician: _____ Phone: _____

Clinic Name: _____

Address, City, State: _____

Authorization to Treat a Minor

I (we) the undersigned parent(s) or legal guardian of _____, a minor do hereby authorize and consent to any x-ray examination, anesthetic, medical, or surgical diagnosis rendered under the general or special supervision of any member of the medical staff and emergency room staff licensed under the provisions of the Medicine Practice Act or a Dentist licensed under the provisions of the Dental Practice Act and on the staff of any acute general hospital holding a current license to operate a hospital from a Department of Public Health and that I (we) agree to be responsible for the cost of such treatment. It is understood this authorization is given in advance of any specific diagnoses, treatment, or hospital care being required but is given to provide authority and power to render care which the aforementioned medical staff in the exercise of his best judgment may deem advisable. It is understood that effort shall be made to contact the undersigned prior to rendering treatment to the patient, but that any of the treatment will not be withheld if the undersigned cannot be reached.

List any Restrictions: _____

It is understood that Centennial School District is not liable for any accident or incident related to transportation by a public carrier.

Parent/Guardian Signature: _____ Date: _____

Type or print name of parent signing: _____ Relationship: _____

Residence address: _____
Address City/State Zip

Phone: _____
Home Work/Father Work/Mother Cell

Other contact person: _____ Phone: _____

Note: Parent permission forms must be returned to the sponsoring teacher.

This consent shall remain effective until revoked in writing.