Parent Permission for School Sponsored Activity

and Consent to Medical Treatment

Please complete both top and bottom of form

(Name of Student)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ has the opportunity to participate in a school activity away from school premises. If you approve the following arrangement, please sign at the bottom of this section and return to the faculty sponsor.

**NATURE OF ACTIVITY**: Veteran’s Day tour

**DESTINATION**: Sterling House of Desoto, Desoto Nursing and Rehab Center, Crescent Place and Crescent Pointe Assisted Living

**DATE­­**: Nov. 11, 2015

**TRIP SUPERVISIOR**: Portia Franklin, Sharetha Hicks, and SFC Don Brookins

I understand the nature of the school activity in which my son/daughter will be participating and that he/she is expected to abide by all school regulations during the course of the activity.

I hereby give my permission for him/her to participate in the above-described activity.

I further agree that, in the event of an accident, illness or any other circumstance requiring medical treatment, such treatment may be procured for my son/daughter without financial obligation to the district.

Date: \_\_\_\_\_\_\_\_\_\_\_ Signature of Parent/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

IMPORTANT MEDICAL INFORMATION THE SUPERVISOR SHOULD KNOW: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMERGENCY TELEPHONE NUMBERS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

AUTHORIZATION TO TREAT A MINOR

I (We), the undersigned parent, parents or legal guardian of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, a minor, do hereby authorize and consent to any x-ray examination, anesthetic, medical or surgical diagnosis and treatment and emergency hospital care which is deemed advisable by an is to be rendered under the general or special supervision of any member of the medical staff and emergency room. It is understood that effort shall be made to contact the undersigned prior to rending treatment to the patient, but that any of the above treatment will not be withheld if the undersigned cannot be reached.

Date:\_\_\_\_\_\_\_\_\_\_\_ Signature of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Father and/or Mother, or Guardian

Allergies to Drugs or Foods \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_-