CHARDON LOCAL SCHOOLS- - -FIELD TRIP FORM

Signed Release Form

I,_______________________________, hereby authorize my son/daughter
(Parent's Name-Print)

_______________________________to participate in the field trip indicated below:
(Student's Name-Print)

Trip Description:____

Trip Length/Date:_____________________________________

CHARDON LOCAL SCHOOLS

Emergency Medical Authorization

In the event **reasonable** attempts to contact me at _______________
(Phone Number)

or other parent/guardian____________________at____________________
(Phone Number)

have been unsuccessful, I hereby give my consent for:

1. The administration of any treatment deemed necessary by a licensed physician or dentist;
2. The transfer of the child to any hospital reasonable accessible.
   This authorization does not include major surgery unless the medical opinions of tw other licensed physicians, concurring in the necessity for such surgery,

I understand that the children will get to the place of the field trip by ____________________.
(Means of Transportation)

In consideration of the child being allowed to participate in the field trip, on behalf of my child, my spouse, a myself, I hereby assume all risks in connection with the field trip and I further release the Board of Education of t Chardon Local School District as an entity, its individual board members, the School District of Chardon Loc District, its Superintendent, administrators and employees and volunteers from all claims, judgments, liability for a injury or damage due to the child's participation in the field trip, including all risks connected, therewith, wheth foreseen or unforeseen. Furthermore, I acknowledge that it is my responsibility to provide adequate health insuran for my child.

____ ________________

(Parent/Guardian) (Date)

This form must be returned BEFORE student will be permitted to take the field trip.

Field Trip Form Revised 10-11-01jhpg

EMERGENCY MEDICAL AUTHORIZATION

School________________ Grade________ Teacher________________

Student Name________________________________

Address________________________ Telephone________________

Purpose – To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority, when parents or guardians cannot be reached.

Residential Parent or Guardian - Please include all parent/guardian daytime phone numbers below (i.e., cell phone, pager).

Mother's Name________________ Daytime Phone________________

Father's Name________________ Daytime Phone________________

Other's Name________________ Daytime Phone________________

Name of Relative or Childcare Provider________________ Relationship________________

Address________________________ Phone________________

PART I OR II MUST BE COMPLETED

PART I – TO GRANT CONSENT

I hereby give consent for the following medical care providers and local hospital to be called:

Doctor________________________ Phone________________

Dentist________________________ Phone________________

Medical Specialist________________________ Phone________________

Local Hospital________________________ Emergency Room Phone________________

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by above-named doctor, or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery. ***Facts concerning the child's medical history including allergies, medications being taken, and any physical impairments to which a physician should be alerted:***

____

____

Date____________ Signature of Parent/Guardian________________________

Address________________________________

PART II – REFUSAL TO CONSENT (DO NOT COMPLETE PART II IF YOU HAVE COMPLETED PART I.)

I do NOT give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take the following action:

____

____

Date____________ Signature of Parent/Guardian________________________

Address________________________________

O.R.C. 3313.712

OVER / PLEASE COMPLETE REVERSE SIDE