ARCHBISHOP HOBAN HIGH SCHOOL

FIELD TRIP PERMISSION SLIP

Student Name_____Class or Organization_____

Teacher Sponsor_____Educational Purpose of Trip_____

Cost_____Location of Trip_____Transportaion_____

Leave School: Date_____Time_____ Return to School: Date_____Time_____

I, _____ the parent/guardian of _____, request that my child be allowed to participate in this field trip. I hereby assume all the risks of my child associated with participation and travel, to and from, and agree to hold Archbishop Hoban High School, its employees, agents, representatives, coaches and volunteers harmless from any and all liability, actions, causes of action, debts, claims, or demands of any kind and nature whatsoever which may arise by or in connection with his/her participation in any activities related to the trip including travel.

I understand that this is a school-sponsored activity and that all applicable policies, rules and regulations contained in the Handbook for Students and Parents are in force.

I have read and understand this form and agree to the above stated conditions.

Parent/Guardian Signature_____Date_____

Phone number where parent/guardian can be reached ***during this activity***: _____

Part I: To Grant Consent for Emergency Medical Treatment

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

Physician_____Phone_____

Dentist_____Phone_____

Medical Specialist_____Phone_____

Local Hospital_____Emerg. Rm. 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 doctors, 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 impairment to which a physician should be alerted:

Parent/Guardian Signature_____Date_____

Street_____City_____Zip_____

Part II: Refusal to Consent

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:

Parent/Guardian Signature_____Date_____

Street_____City_____Zip_____