



SCHOOL DISTRICT OF ASHLAND

**PARENT/GUARDIAN PERMISSION FOR SCHOOL SPONSORED FIELD TRIP
CONSENT TO MEDICAL TREATMENT AND RELEASE OF INFORMATION**

Please complete and return this form by _____ (date).

STUDENT NAME: _____ has the opportunity to participate in a school activity away from school premises. If you approve your student's participation, please sign and return to the Teacher / Advisor.

NATURE OF ACTIVITY: _____

DESTINATION: _____

DATE(S): _____

DATE/TIME OF DEPARTURE: _____ **DATE/TIME OF RETURN:** _____

TEACHER / ADVISOR: _____

MEANS OF TRANSPORTATION: (Please specify)

- A. District-Owned Vehicle(s) _____
- B. Commercial (Name of Company) _____
- C. Other (Specify) _____

PARENT/GUARDIAN:

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.

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. I do further authorize emergency treatment to be initiated at any medical facility to which my son /daughter has been transported.

I further agree that if my son/daughter receives medical treatment and/or is hospitalized, his/her name shall be released to school district officials upon their request.

IMPORTANT MEDICAL INFORMATION THE TEACHER / ADVISOR SHOULD KNOW: _____

EMERGENCY CONTACT NAME: _____ **TELEPHONE NUMBER:** _____

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THIS FORM SHALL BE KEPT BY THE TEACHER / ADVISOR / CHAPERONE DURING THE FIELD TRIP ACTIVITY AND A COPY LEFT AT THE SCHOOL OFFICE.

Parent/Guardian Signature: _____ **Date:** _____