

This form serves as a permission slip for ALL regular field trips.

WORTHINGTON CITY SCHOOL DISTRICT

Blanket Field Trip Permission and Emergency Medical Authorization Form

The school requires written permission from a parent or guardian of each child before she/he may participate in field trips. Transportation for field trips will be by school bus or walking. **I hereby grant permission for my child to participate in field trips during the current school year.** I release the Worthington City Board of Education and school employees from any and all liability of any kind which may arise during or relating to the trip except liability for damages and injuries caused by the sole negligence of the Worthington City School District. Notification will be sent to parents or guardians prior to any field trip indicating dates, times, and destinations.

Signature of Parent or Legal Guardian

Date

Please complete the **Emergency Medical Authorization** section of this form. Please inform the school of any changes in this authorization as they occur and prior to each field trip.

SECTIONS 1 and 3: COMPLETE IF YOU ARE **GIVING CONSENT** TO EMERGENCY TREATMENT.
SECTION 2: COMPLETE IF YOU ARE **NOT GIVING CONSENT** TO EMERGENCY TREATMENT.

Emergency Medical Authorization

SECTION 1: CONSENT TO EMERGENCY TREATMENT

Student Name _____
Address _____
Telephone _____

School _____
Teacher _____
Grade _____
Birthdate _____

Purpose: To enable parents or 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. In the event of an emergency, please call:

- | | | |
|--------------------|--------|------------------|
| 1. Name _____ | Mother | Home Phone _____ |
| | | Work Phone _____ |
| | | Pager/Cell _____ |
| 2. Name _____ | Father | Home Phone _____ |
| | | Work Phone _____ |
| | | Pager/Cell _____ |
| 3. Name _____ | Other | Home Phone _____ |
| Relationship _____ | | Work Phone _____ |
| | | Pager/Cell _____ |

In the event reasonable attempts to contact the above-mentioned have been unsuccessful, I hereby give my consent for the administration of any treatment deemed necessary by:

- | | |
|------------------------------|-------------|
| 1. Preferred Physician _____ | Phone _____ |
| 2. Preferred Dentist _____ | Phone _____ |
| 3. M.D. Specialist _____ | Phone _____ |

In the event the designated preferred practioner(s) are not available, by another licensed physician or dentist; and the transfer of the child to

- | | |
|-----------------------------|-------------|
| 1. Preferred Hospital _____ | Phone _____ |
|-----------------------------|-------------|

or any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinions of two licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Signature of Parent or Legal Guardian

Date

Emergency Medical Authorization

SECTION 2: REFUSAL TO CONSENT TO EMERGENCY TREATMENT

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 school authorities to TAKE NO ACTION OR TO _____

Signature of Parent or Legal Guardian _____

Date _____

Emergency Medical Authorization

SECTION 3: EMERGENCY MEDICAL INFORMATION

Food Allergies _____

Medicine Allergies _____

Insect Allergies _____

Other Allergies _____

Is EPI-PEN required? YES ___ NO ___

Current Medications:

Name _____ Dosage _____ Frequency _____

Name _____ Dosage _____ Frequency _____

Name _____ Dosage _____ Frequency _____

Health Concerns (Diabetes, Asthma, etc.) _____