

**CHAGRIN FALLS HIGH SCHOOL
FIELD TRIP PERMISSION FORM AND EMERGENCY MEDICAL AUTHORIZATION FORM**


DIRECTIONS: *Parent/Guardian must complete his/her part of this form for student to be allowed to attend the stated field trip. **Either Part I or Part II must be completed.***

_____ Student Name _____ Student ID # _____ Age _____


FIELD TRIP PERMISSION

I grant permission for my child, _____ to attend the field trip to, _____
_____ with his or her teacher, Mr./Mrs./Ms. _____ on this date: _____

As the parent/guardian, I, _____, agree to release and hold harmless Chagrin Falls Exempted Village Schools, Chagrin Falls High School Administrators, and/or any Chagrin Falls High School staff from any and all liability, loss, damages, claims or, actions for bodily injury and/or property damages in accordance with current State and Federal law, arising out of participation in this field trip.

 _____ / / _____
(Signature of Parent/Guardian) (Date)

As a student of Chagrin Falls High School, I agree to follow all school rules during this school sponsored trip.

 _____ / / _____
(Signature of Student) (Date)

MEDICAL AUTHORIZATION

_____ (Parent or Guardian)	_____ (Home #)	_____ (Cell #)
_____ (Parent or Guardian)	_____ (Home #)	_____ (Cell #)
_____ (Doctor)	_____ (Phone #)	_____ (Hospital)
_____ (Medical Specialist)	_____ (Phone #)	_____ (Hospital)
_____ (Dentist)	_____ (Phone #)	

√ **Part I (Consent for Treatment)**

I hereby given consent for the medical care providers listed within to be called. In the event reasonable attempts to contact parent(s)/guardian(s) listed above 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 reasonably accessible hospital. This authorization does not cover major surgery unless the medical opinions of two (2) other licenses 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 are listed below:

(Signature of Parent/Guardian) (Date) (Address)

√ **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 to take no action or attempt to provide any medical attention.

(Signature of Parent/Guardian) (Date) (Address)