Forbes Road Elementary School
Parent Permission For School Sponsored Activity
And Consent to Medical Treatment

Please complete both top and bottom of this form. The bottom will be kept with a supervisor of the trip.

(Student) _____ has the opportunity to participate in a school activity away from school premises. If you approve the following arrangement, please sign at the bottom of this section and return to the faculty sponsor.

NATURE OF ACTIVITY – _____
DESTINATION – _____
DATE – _____ **TIME OF DEPARTURE –** _____ **TIME OF RETURN –** _____
TRIP SUPERVISOR(S) – _____
MEANS OF TRANSPORTATION: _____

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 understand that the district is liable or responsible for the conduct or safety of my son/daughter only while he/she is or should be under the immediate and direct supervision of an employee of the district.

I hereby give my permission for him/her to participate in the above-described activity.

I further agree that, 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.

Date: _____ Signature of Parent/Guardian _____

Important medical information the trip supervisor should know including medication that the teacher should have for the student on the trip: _____

_____

EMERGENCY TELEPHONE NUMBERS: _____

AUTHORIZATION TO TREAT A MINOR

I (We), the undersigned parent, parents or legal guardian of _____, a minor, do hereby authorize and consent to any x-ray examination, anesthetic, medical or surgical diagnosis and treatment and emergency hospital care which is deemed advisable by and is to be rendered under the general or special supervision of any member of the medical staff and emergency room staff licensed under the provisions of the Medicine Practice Act and on the staff of any acute general hospital holding a current license to operate a hospital from the State of Pennsylvania Department of Public Health. It is understood that effort shall be made to contact the undersigned prior to rendering treatment to the patient, but that any of the above treatment will not be withheld if the undersigned cannot be reached.

Date: _____ Signature _____
Father and/or Mother, or Guardian

Allergies to Drugs or Foods _____

Date of last Tetanus Toxoid Booster _____