

***Kings Local School District***  
**PERMIT FOR FIELD TRIPS**

The purpose of this form is to secure permission from parent(s)/guardian(s) so that their child/children may participate in class/PTO sponsored field trips. This permission form will be applicable for the current school year only. The classroom teacher will be responsible for notifying the parents prior to all field trips.

Permission is granted to \_\_\_\_\_ to go on field trips under the supervision of a Kings Local School District professional staff member.

Parent(s)/guardian(s) will be notified prior to all field trips during the (Applicable to **2011-2012**) school year.

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Signature of Parent/Guardian \_\_\_\_\_

**Emergency Medical Authorization**

Student Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

**CONTACT 1: Parent/Guardian to Contact** \_\_\_\_\_

Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Daytime Phone \_\_\_\_\_ Cell/pager \_\_\_\_\_

**EMERGENCY INFORMATION**

List in order how contacts are to be made in the event of an emergency, discipline, attendance, etc.  
(Parent listed above will be the first contact.)

**CONTACT 2**

**CONTACT 3**

**CONTACT 4**

**Name:** \_\_\_\_\_ **Name:** \_\_\_\_\_ **Name:** \_\_\_\_\_

**Relationship:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

**Day/Work #:** \_\_\_\_\_ **Day/Work #:** \_\_\_\_\_ **Day/Work #:** \_\_\_\_\_

**Cell/Pager :** \_\_\_\_\_ **Cell/Pager :** \_\_\_\_\_ **Cell/Pager :** \_\_\_\_\_

PURPOSE: To make it possible for parent(s)/guardian(s) to authorize the provision of emergency treatment for children who become ill or injured while under school authority, if parent(s)/guardian(s) cannot be reached, for the purpose of giving consent for such treatment. Such authority is necessary to overcome legal obstacles to the provision of such treatment when all reasonable attempts to reach parent(s)/guardian(s) have failed. You can authorize such emergency medical treatment for your child/children by completing this form.

**I hereby give my consent, in the event of all reasonable attempts to contact me or the other contacts listed above have been unsuccessful, for the (1) administration of any treatment deemed necessary by:**

**Doctor:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Dentist:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Medical Specialist:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Insurance:** \_\_\_\_\_

**After notifying my child's/children's medical personnel, (2) transfer my child to the following hospital:**

**Preferred Hospital:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Pertinent facts to which physician should be alerted, i.e., physical impairment (heart, epilepsy, etc.), allergies, medications being taken, other facts:**

\_\_\_\_\_  
\_\_\_\_\_

**DATE:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Signature of Parent/Guardian:** \_\_\_\_\_