



ST. VINCENT-ST. MARY HIGH SCHOOL
 15 NORTH MAPLE STREET AKRON, OHIO 44303 330-253-9115

ST. VINCENT – ST. MARY HIGH SCHOOL
 PERMISSION SLIP

Student Name _____
 Class or Organization _____

Teacher Sponsor Signature _____ Date _____

Objective/Purpose of Trip _____

Location of Trip _____

Transportation _____

Leave School: Date _____ Time _____

Return To School Date _____ Time _____

I, _____ the parent/guardian of _____
 agree to allow my child to participate in this activity or field trip. I hereby
 assume all the risks associated with participation and travel, to and from, and
 agree to hold St. Vincent-St. Mary High School, its employees, agents,
 representatives, coaches, and volunteers harmless from any and all liability,
 actions, causes of action, debts, claims, or demands of any kind and nature
 whatsoever which may by or in connection with his/her participation in any
 activities related to the trip including travel.

I have read and understand this form and agree to the above stated conditions.

Parent Signature _____ Date _____

Phone Number where Parent Can Be Reached During This Activity _____

PART ONE: To Grant Consent For Emergency Medical Treatment
 I hereby give consent for the following medical care providers and hospital to be
 called:

Physician _____ Phone # _____

Dentist _____ Phone # _____

Medical Specialist _____ Phone # _____

In the event reasonable attempts to contact me 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 practitioner is not available, by
 another licensed physician or dentist; and (2) the transfer of the child to any hospital
 reasonable accessible.

This authorization does not cover major surgery unless the medical opinions of two
 other licensed 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:

Date _____ Signature of Parent/Guardian _____

Address _____

City _____ State _____ Zip Code _____

PART TWO: 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 authorities to take
 the following
 action: _____

Date _____ Signature of Parent/Guardian _____

Address _____

City _____ State _____ Zip Code _____