ST. VINCENT-ST. MARY HIGH SCHOOL
15 NORTH MAPLE STREET AKRON, OHIO 44303 330-253-9113

ST. VINCENT – ST. MARY HIGH SCHOOL PERMISSION SLIP

Student Name _____

Class or Organization: **STVM Juniors/Sophomores/Freshmen**

Teacher Sponsor Signature **Mr. Brownfield** **Date 5/1/2017**

Objective/Purpose of Trip: **Cedar Point Trip**

Location of Trip: **Cedar Point**

Transportation **Provided-School Bus**

Leave School: Date: **5/19/17** Time: **8:00 am**

Return To School Date: **5/19/17** Time: **8:00 pm**

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 impairment 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