Central Square Central School District

Overnight Field Trip Parent/Guardian Consent Form

Your child will be participating in an overnight field trip. Please read and discuss with your child the information packet for the trip.

Medication will not be administered to your child unless there is an order from a licensed physician and a note of direction from a parent/legal guardian. This includes any prescription and/or over the counter medications, such as Tylenol, Motrin, allergy medications and inhalers. The Medical Treatment Authorization form must also be filled out.

As parent/legal guardian of _____, I grant permission for my child to
(Print Student's Name)
participate in the overnight field trip described below (to be completed by school):

School:		**Date:**	
Reason for Travel:			
Chaperones:			
Destination: Place		**City/State**	
Departure: Date		**Time**	
Return: Date		**Time**	

Student Medical Alerts: _____

Medications Being Taken: _____

Printed Name of Parent/Guardian: _____ Date: _____

Signature of Parent/Guardian: _____ Date: _____

I am aware that when I am on a school-sponsored trip, I am under the jurisdiction and supervision of the school-employed chaperones and that my behavior must conform to the Student Code of Conduct, the Student Handbook, and the reasonable instructions from chaperones.

By signing below, I understand I will be subject to appropriate disciplinary action for violations of these rules and regulations.

_____ _____

Signature of Student Date

If your child needs medical, dental, health, or hospital services, you as a parent must give permission. It's the law.

What about times when you cannot be reached for permission? A child may be treated without parental consent when a physician determines a true emergency exists. That means the doctor determines the child needs immediate medical care and that an attempt to obtain parental consent would result in a delay, which would increase the risk to the child's life or health.

Except in a true emergency, care may be ordinarily rendered to a child only with the consent of the parent or legal guardian. Sometimes a child may need unexpected care, which is not, however, a true emergency. In such cases, making an effort to contact a parent for permission can delay treatment and create unnecessary anxious moments for the child.

You can prepare for unexpected care your children might need when you are away from home. To do this, make sure babysitters know how to reach you at all times. And when you know you will be hard to reach, you can give permission to other adults. They can then act for you by permitting your child to be treated if unexpected care is needed.

This is a legal document. With it you may appoint relatives, friends teachers, clergy, neighbors - anyone who is over 18 years of age - to be responsible for your children when you are away from them. It is especially important to prepare this form for the occasions when you know it will be hard to contact you.

Fill out this form carefully. Have your signature witnessed by an adult different from the person you are making responsible for your children.

After you complete this form, give it to the adult(s) you have named to act on your behalf. If your child needs unexpected medical treatment, the responsible adult(s) should present this document to the appropriate person - physician, dentist or hospital representative.

Authorization

for medical treatment of minors

NAMES OF MINORS	BIRTH DATES	IDENTIFY ALLERGIES OR SPECIAL CONDITIONS

I/We, being the parent(s) or legal guardian(s) of the above named minor(s), do hereby appoint:

Name	Address	Phone
Name	Address	Phone

To act in my/our behalf in authorizing unexpected medical, dental, surgical care and hospitalization for the above named minor(s) during the period of my/our absence, from:

MONTH	DAY	YEAR	THROUGH	MONTH	DAY	YEAR

This document shall be presented to a physician, dentist or appropriate hospital representative at such time as unexpected medical, dental, surgical care or hospitalization may be required.

PARENT/GUARDIAN		PARENT/GUARDIAN	
Signature		Signature	
Address	Date	Address	Date
Witness		**Witness**	
Signature		Signature	
Address	Date	Address	Date

HOSPITALIZATION COVERAGE FOR ABOVE NAMED MINOR(S):

Insurance Company or Government Program	I.D. or Contract Number

FAMILY PHYSICIANS:

Name and Phone Number	Name and Phone Number