Chardon High School

PARENT CONSENT FOR TRIP

I, ________________________________ (Parent's Name), permit my child,

________________________________, to participate in the trip to

New York City Latino Experience Field Trip on April 20-22, 2023
________________________________.

☐ I understand that this trip is part of the District's educational program and provides a learning experience of educational value to my child.

☐ I further understand that the staff member(s) who will accompany the students on this field trip, will exercise the necessary and appropriate duty of care for them pursuant to Board Policy 3213, including, but not limited to, administering medication, if required, or seeking emergency medical attention, if need be.

________________________________ ________________________________

Parent Date

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EMERGENCY MEDICAL AUTHORIZATION

School Chardon High School ______ Grade ______ Teacher Kristen Niedzwiecki ______

Student Name ______

Address ______ Telephone ______

Purpose – To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority, when parents or guardians cannot be reached.

Residential Parent or Guardian - **Please include all parent/guardian daytime phone numbers below (i.e., cell phone, pager).**

Mother's Name ______ Daytime Phone ______

Father's Name ______ Daytime Phone ______

Other's Name ______ Daytime Phone ______

Name of Relative or Childcare Provider ______ Relationship ______

Address ______ Phone ______

PART I OR II MUST BE COMPLETED

PART I – TO GRANT CONSENT

I hereby give consent for the following medical care providers and local hospital to be called:

Doctor ______ Phone ______

Dentist ______ Phone ______

Medical Specialist ______ Phone ______

Local Hospital ______ Emergency Room 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 doctor, or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to any hospital reasonably 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 ______

PART II – REFUSAL TO CONSENT (DO NOT COMPLETE PART II IF YOU HAVE COMPLETED PART I.)

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 ______

O.R.C. 3313.712

OVER / PLEASE COMPLETE REVERSE SIDE.