



PICKERINGTON LOCAL SCHOOL DISTRICT

90 East Street, Pickerington, Ohio 43147
Phone: 614-833-2110 Fax: 614-833-2143
www.pickerington.k12.oh.us

**FIELD TRIP PERMIT AND
EMERGENCY MEDICAL AUTHORIZATION**

Student Name: _____ Birth Date: _____

has my permission to attend the _____
(Name of class, club, group or organization)

field trip on _____ to _____
(Date of event) (Destination)

To enable parents/guardians to authorize the provision of emergency treatment for students who become ill or injured while under school authority when parents/guardians cannot be reached the **Emergency Medical Authorization form**, attached to this permission slip, **MUST be completed**.

Parent/guardians must choose between Part I – To Grant Consent or Part II – Refusal to Consent on the Emergency Medical Authorization form.

I grant permission for my student to attend the above listed field trip and verify by my signature that I have completed the Emergency Medical Authorization information.

(Date)

(Print name of Parent/Guardian)

(Contact Phone Number)

(Signature of Parent/Guardian)

**THE EMERGENCY MEDICAL AUTHORIZATION FORM IS ATTACHED
TO THIS SHEET AND MUST BE COMPLETED.**



PICKERINGTON LOCAL SCHOOL DISTRICT

90 East Street, Pickerington, Ohio 43147
Phone: 614-833-2110 Fax: 614-833-2143
www.pickerington.k12.oh.us

EMERGENCY MEDICAL AUTHORIZATION

School: _____

Student Name: _____ Birth Date: _____ Grade: _____ Homeroom: _____

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.

Table with 5 columns: Residential Parent or Guardian Information, Home Phone, Work Phone, Cell Phone, E-mail Address. Rows include Mother's Name, Father's Name, Alternate Contact Name, Address, and Relationship to child.

PART I OR PART II MUST BE COMPLETED

PART I - TO GRANT CONSENT

I hereby give consent for the following medial 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.
• Pertinent health information will be shared with appropriate school staff only on a need-to-know basis.
• 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

PART II - 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