BUCKEYE CENTRAL HIGH SCHOOL
FIELD TRIP NOTICE

Field Trip destination _____

Student name _____ Trip Date _____

Time leaving school _____ Approximate time returning _____

Items required for trip _____

Means of transportation _____

Yes, I wish to have _____ go on this field trip.

Signed _____
Parent/Guardian

BUCKEYE CENTRAL HIGH SCHOOL
NEW WASHINGTON, OH 44854
FIELD TRIP EMERGENCY MEDICAL AUTHORIZATION

Name _____ Phone Number _____

Address _____

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.

PART I OR II MUST BE COMPLETED

PART I TO GRANT CONSENT

In the event reasonable attempts to contact me at _____(ph. #) or _____ (other parent or guardian) at _____(ph. #) have been unsuccessful, I hereby give my consent for: (1) the administration of any treatment deemed necessary by Dr. _____(preferred physician & ph.#) or Dr. _____(preferred dentist & ph. #), or, in the event the designated preferred practitioner is not available, by other licensed physician or dentist; and (2) the transfer of the child to _____(preferred hospital) or 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.

Please list facts concerning the child's medical history including allergies, medications being taken and any physical impairments to which a physician should be alerted: _____

_____

Date _____ Signed _____
Parent/Guardian

DO NOT COMPLETE PART II IF YOU COMPLETED PART I

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 no action or to:

_____

Date _____ Signed _____
Parent / Guardian