School: _____

Participants name: _____

Destination: _____

TO WHOM IT MAY CONCERN:
I/We understand that first aid will be available on the above trip. I/We further understand that should an accident, injury or illness occur, medical and/or hospital care will be obtained.

I/We realize that the sponsors will make a reasonable effort to notify me/us in case of accident, injury or illness; however, should they be unable to contact me/us, they have my permission to pursue a course of medical action which is in the best interest of the child.

I/We grant permission to the administration of first aid care to (name) by the people in charge and those transporting my child and from their judgment deems advisable and to make the necessary referrals to qualified physicians or health care providers for treatment of illness or accidents. I/We understand that a reasonable effort will be made to promptly notify me in the event of any serious illness or accident and prior to any major surgery, except when delay in such communication would endanger life. In case of medical emergency, in the event I/we cannot be reached, I/we hereby give permission to the physician or health care provider selected by the adult staff to hospitalize secure proper treatment for and order whatever injection, anesthesia or surgery said physician or health care provider deems necessary for the child.

A doctor, clinic, hospital or health care provider may proceed with a medical or surgical treatment that such sponsor may authorize.

I further understand that I will be responsible for all medical, surgical and transportation costs which may be incurred.

INSURANCE INFORMATION

Insurance Company Policy No._____

_____ _____
(Father) (Home & Work Telephone #)

_____ _____
(Mother) (Home & Work Telephone #)

If unable to contact either parent above I/we grant permission to contact:

_____ _____
Friend or Relative (Home & Work Telephone #)

EMERGENCY CARE INFORMATION

Child's Full Name:_____

Date of Birth:_____ Date last Tetanus Shot_____

Child is allergic to the following medications_____( ) None

Child is taking the following medications_____( ) None

Child is diabetic, has other chronic condition or major illness_____( ) None

Name of primary care physician and phone number_____

_____ _____ _____ _____
Parent/Legal Guardian Signature Date Parent/Legal Guardian Signature Date

State of _____ County of_____

Sworn and subscribed before me this _____day of _____ in the year of 20____ by_____

_____who is personally known to me _____ or produced a driver's license

for identification_____ driver's license number

Notary Signature:_____

Seal:

My Commission Expires:_____