

# FIELD TRIP AND EMERGENCY AUTHORIZATION FORM

This Field Trip Permit Form will be good through the \_\_\_\_\_ - \_\_\_\_\_ school year.

**Brookfield High School, 614 Bedford Road SE, Brookfield, OH 44403**

Field Trip To: \_\_\_\_\_

Field Trip Date: \_\_\_\_\_

## STUDENT INFORMATION

Last Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

First Name: \_\_\_\_\_ Grade: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

ANY MEDICAL PROBLEMS? \_\_\_\_\_

## PARENT/GUARDIAN/PHYSICIAN/HOSPITAL INFORMATION

Father's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Employer Phone: \_\_\_\_\_

Mother's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Employer Phone: \_\_\_\_\_

Alternate Person to Notify: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Doctor to Notify: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Preferred Hospital: \_\_\_\_\_

Phone Number: \_\_\_\_\_

I hereby voluntarily consent to emergency treatment and first-aid, screening examinations, and minor treatment as may be deemed necessary by the school physician or school nurse. When unable to contact parent or personal physician, I hereby give permission to the school physician to authorize treatment needed (at local hospitals) until parent and/or personal physician can be notified.

Yes \_\_\_\_\_ No \_\_\_\_\_

Date Signed: \_\_\_\_\_ Parent Signature: \_\_\_\_\_