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: _____