

SMS PERMISSION SLIP FOR 8TH GRADE WASHINGTON TRIP

(Student's name-print)

(Team)

I have read the preceding pages with my child and we both understand all the rules and procedures. I give my child permission to attend the 8th Grade trip. Further, I realize that I am responsible and liable for the actions of my child even when she/he is under the supervision of Solon Middle School. *Two separate forms must be completed with parent signature; both forms are necessary, one for us and one for the tour company. Thank you!*

(Parent/Guardian Signature)

(Cell Phone Number)

I have read the preceding pages and I agree to follow all school rules and procedures of the trip.

Does the student require an epipen? Yes____No____

Does the student require an inhaler? Yes____No____

Does the student have allergies? Yes____No____

If so, please explain_____

Is the student prone to bus sickness? Yes____No____

Does the student have any physical problems that might impair traveling?
Yes____No____ If yes, please explain_____

Will the student be on medication that should be handled by the teacher?
Yes____No____ If yes, please explain_____

Do you give permission for SMS to dispense over-the-counter medication?
Yes____No____ If yes, what types (Tylenol, Advil, Midol, etc.)

TRAVEL AUTHORIZATION & MEDICAL TREATMENT OF MINORS



(PLEASE PRINT)

NAME OF MINOR	BIRTHDATE	SOCIAL SECURITY #	ALLERGIES, MEDICATIONS, ETC.	LAST TETANUS SHOT

I/We, being the parent(s) or legal guardian of the above named minor, do hereby allow travel to: _____ and appoint:

NAME Mr. Scott Hatteberg	SCHOOL SMS	PHONE 440.349.7398
NAME Mr. Ed Bubonics	SCHOOL SMS	PHONE

to act in my/our behalf in authorizing travel and/or unexpected medical, dental, surgical care and hospitalization for the above named minor during the following period of my/our absence, from:

MONTH	DAY	YEAR	through	MONTH	DAY	YEAR
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This document shall be presented to an immigration officer, physician, dentist or appropriate hospital representative at such time as requested or if unexpected medical, dentist, surgical care or hospitalization may be required. I/We, the undersigned parent(s) / guardian(s) also assume ALL financial responsibility that may be incurred in the course of such care.

PARENT (MOTHER) / GUARDIAN		PARENT (FATHER) / GUARDIAN	
NAME (PRINT)	MOTHER'S MAIDEN NAME	NAME (PRINT)	
ADDRESS		ADDRESS	
HOME TELEPHONE		HOME TELEPHONE	
WORK TELEPHONE		WORK TELEPHONE	
<u>SIGNATURE</u>	DATE	<u>SIGNATURE</u>	DATE
WITNESS SIGNATURE	DATE	WITNESS SIGNATURE	DATE

HOSPITALIZATION COVERAGE FOR ABOVE NAMED MINOR

COMPANY OR GOVERNMENT PROGRAM	I.D. / CONTRACT NUMBER	CLAIMS OFFICE TELEPHONE #

FAMILY PHYSICIAN(S)
NAME & TELEPHONE NUMBER

NAME & TELEPHONE NUMBER

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If your child needs medical, dental, health or hospital services, you as a parent/legal guardian must give permission. **IT'S THE LAW.**

A child may be treated without consent when a physician determines a true emergency exists. This means a doctor may determine that the child needs immediate medical care, and that an attempt to obtain consent would result in a delay which would increase the risk to the child's life or health. However, unless such a true emergency exists, care may only be given to a child with the permission of the parent/legal guardian.

By signing and having this form witnessed, you give the above name adult(s) permission to have your child treated if unexpected care is needed and you cannot be reached.

Have your signature witnessed by an adult different from the person you are making responsible for your child. After this form is completed, give it to the adult(s) you have named above to act on your behalf. The information on this form is **STRICLTLY CONFIDENTIAL.**