



# Fruitland High School

Michael Fitch, Principal

Jennifer Thornfeldt, Achievement Specialist ♦ Lisa O'Neil, Counselor ♦ Beth Holt, Athletic Director ♦ Jennifer Teetzen, Admin. Asst.

## FIELD TRIP PERMISSION SLIP

To the Parent/Guardian: \_\_\_\_\_ Date \_\_\_\_\_

I give my permission for \_\_\_\_\_ Grade \_\_\_\_\_

(Student Name-PLEASE PRINT)

to go on the following field trip with Fruitland High School.

**Date(s):**

**Class/Club:**

**Location(s):**

The field trip will be an Activity Absence. **The student should arrange his/her absence at least 2 days in advance by requesting assignments from each class that will be missed. Make up work will be turned in at the teacher's discretion.**

**Student Signature:** \_\_\_\_\_

### AUTHORIZATION FOR CONSENT TO TREATMENT OF MINORS

While attending school-sponsored field trips, I hereby authorize the teacher of said class, or in his/her absence or disability, any adult accompanying him/her to consent to any X-ray examination, any anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is rendered under the general or special supervision of any physician and/or surgeon. Or, to consent to an X-ray examination, anesthetic, dental or surgical diagnosis or treatment and hospital care to be rendered to said minor by a dentist licensed under the provision of the Dental Practice Act.

The authorization is given for the protection of said student and of the Fruitland School District #373, under and pursuant to the laws of the said state governing such cases.

**I understand this information will be in the teacher's possession for the duration of all field trips.**

Parent Name: \_\_\_\_\_ Phone # \_\_\_\_\_

If the parent or legal guardian cannot be contacted in an emergency, the following should be called:

Name: \_\_\_\_\_ Phone # \_\_\_\_\_

Medication(s) being taken currently: \_\_\_\_\_

Allergies: \_\_\_\_\_

Additional medical information you feel we should know: \_\_\_\_\_

**Please attach written instructions if a student has a health problem that can be administered to immediately.**

Insurance Company \_\_\_\_\_ Policy Number \_\_\_\_\_

This authorization shall remain effective for the dates listed above.

**Parent Signature** \_\_\_\_\_ Phone Number \_\_\_\_\_