

STUDENT FIELD TRIP/EXTENDED TRAVEL AUTHORIZATION TO CONSENT TO TREATMENT OF STUDENT 2023-2024 School Year

STUDENT NAME	GRADE
Home or Emergency Phone #	
Address	
Family Doctor	Hospital
staff member of the School District of La C undersigned, to consent to any x-ray examina and hospital care which is deemed advisable b	e above mentioned student minor do hereby authorize the crosse supervising the activity concerned, as agent for the ation, anesthetic, medical or surgical diagnosis or treatments, and is to be rendered under general or special supervisional staff of any licensed hospital whether such diagnosis of ician at the said hospital.
care being required but is given to provide aut	n in advance of any specific diagnosis, treatment or hospita thority and power on the part of the aforesaid agent to give sis, treatment or hospital care which the aforementioned ent may deem advisable.
	ne authority to call for emergency medical transportation o benefit of the involved student, as the staff person deems
Every effort will be made to contact parents or involved treatment. This authorization shall rem	guardians to explain the nature of the problem prior to any nain effective until the end of the school year.
Signature of Parent/Guardian	Date Signed
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WALKING FIELD TRIP	PERMISSION/CONSENT TO TREAT
the entire school year. I understand that if I has field trips I should convey such requests in	n field trips within walking distance from my child's school fo have any special concerns regarding my child participating in writing to the supervising teacher. If possible, such specia that my child will abide by the instructions given by the
Signature of Parent/Guardian	Date Signed