Teacher (Elementary Only) _____ **Grade** _____ **Team** (TMS only)_____

TOMAH AREA SCHOOL DISTRICT

FIELD/ORGANIZATIONAL PERMISSION FORM - MULTIPLE USE and AUTHORIZATION TO CONSENT TO TREATMENT OF STUDENT

This form must be on file in the school office before the student may participate in any field trip.

Student Name: _____
(Last) (First)

Phone Number: _____

Address: _____

Family Doctor: _____ Phone Number: _____

We, the undersigned parent(s)/guardian(s) of the above-mentioned student, hereby give my/our permission for him/her to go on any class field trip set up through the school for the entire year of **2022-2023.**

If you have any special request(s) to make concerning your child's participation in field/organization trips, you should convey your request(s) in writing to the teacher/advisor in charge. If possible, your special requests will be honored. It is understood that the student must abide by the directions given by the supervising teacher. If for behavioral/disciplinary reasons, your child must return from the trip early and separate from the group, you will be responsible for any additional incurred trip expenses.

We, the undersigned parents/guardians of the above-mentioned minor student, do hereby authorize the staff member of the Tomah Area School District, supervising the activity concerned, as agent for the undersigned, to consent to an x-ray examination, anesthetic, medical, or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to rendered under general or special supervision of, any physician and surgeon on the medical staff of any hospital whether such diagnosis or treatment is rendered at the office of said physician or at the said hospital.

It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required, but is given to provide authority and power on the part of our aforesaid agent to give physical care in the exercise of his/her best judgment that may be deemed advisable.

Every effort will be made to contact parents or guardians to explain the nature of the problem prior to any involved treatment. This authorization shall remain effective until the end of the school year.

_____ _____
(Parent/Guardian Signature) (Date)

Does your child have any health condition or required special accommodations the teacher/advisor should be aware of? No ____ Yes ____ Please explain.

Emergency Contact Name: _____ Phone: _____