

**OLENTANGY LIBERTY HIGH SCHOOL**  
**Field Trip Permission**  
**(PLEASE PRINT)**

**Student's Name:** \_\_\_\_\_ **Home Phone** \_\_\_\_\_

The above named student has my permission to Mansfield Senior Arlin Field/Football State Semi-Final Game  
DESTINATION OF FIELD TRIP

With the: Olentangy Liberty High School class on: Friday, November 23, 2018  
Date

**I understand students will be traveling by school vehicle, leaving OLHS at 5:15 PM and returning by 11:00 PM I understand all school rules will be followed while away from the building.**

\_\_\_\_\_  
*SIGNATURE OF PARENT/GUARDIAN*

\_\_\_\_\_  
*DATE*

**EMERGENCY CONTACTS**

\_\_\_\_\_  
RESIDENTIAL PARENT OR GUARDIAN MOTHER'S FIRST AND LAST NAME

HOME PHONE (\_\_\_\_) \_\_\_\_\_  
WORK PHONE (\_\_\_\_) \_\_\_\_\_

\_\_\_\_\_  
RESIDENTIAL PARENT OR GUARDIAN FATHER'S FIRST AND LAST NAME

HOME PHONE (\_\_\_\_) \_\_\_\_\_  
WORK PHONE (\_\_\_\_) \_\_\_\_\_

\_\_\_\_\_  
OTHER PARENT, GUARIAN OR RELATIVE'S FIRST AND LAST NAME (RELATIONSHIP)

HOME PHONE (\_\_\_\_) \_\_\_\_\_  
WORK PHONE (\_\_\_\_) \_\_\_\_\_

\_\_\_\_\_  
IF PARENT / GUARDIAN CANNOT BE REACHED – EMERGENCY CONTACT FIRST AND LAST NAME

HOME PHONE (\_\_\_\_) \_\_\_\_\_  
WORK PHONE (\_\_\_\_) \_\_\_\_\_

*The purpose of this form is to enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority, when parents or guardians cannot be reached.*

**THIS SECTION MUST BE COMPLETED**

**PART I: TO GRANT CONSENT:**

*I hereby give consent for the following medical care providers and local hospital to be called:*

\_\_\_\_\_  
PHYSICIAN

PHONE \_\_\_\_\_

\_\_\_\_\_  
DENTIST

PHONE \_\_\_\_\_

\_\_\_\_\_  
MEDICAL SPECIALIST

PHONE \_\_\_\_\_

\_\_\_\_\_  
LOCAL HOSPITAL

PHONE \_\_\_\_\_

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for: (1) the administration of any treatment deemed necessary by above-named doctors, or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to a hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Facts concerning the child's medical history, including allergies, medications being taken, and any physical impairments to which a physician should be alerted are listed as follows:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**