

# BACK TO SCHOOL BEACH BLAST 011 Grades 7-12



## Hillcrest Christian School Event Permission Slip

Student: \_\_\_\_\_ Grade: \_\_\_\_\_ Date: Sept. 2, 2005

Cost: \$5.00 Cash Only/Checks OK Time Leaving: 11:30am Time Returning: 4:00pm

Transportation: Bus – Mandatory for Everyone Bring Lunch, Water, Towel & Suntan Lotion

Boogie Boards & Skim Boards OK to bring - NO Surfboards

Medical Insurance Carrier: \_\_\_\_\_ Group Number: \_\_\_\_\_

Personal Physician: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Allergies (including food/medical conditions) \_\_\_\_\_

List all medication your child is currently taking: \_\_\_\_\_

List medication your child needs while on field trip: \_\_\_\_\_

(Please send only one dose of medication in proper prescription bottle with the child and include a note giving permission for the child to take medication while on field trip.)

I hereby give my permission for the above-named child to attend this event. I give my permission for this child to receive emergency medical attention if a situation warrants such treatment.

I/We the undersigned, parent(s) or legal guardian do hereby authorize any X-ray examination, anesthetic, dental, medical, or surgical diagnosis or treatment by any licensed physician or dentist, and any hospital service that may be rendered to said minor under the general, specific, or special consent of an acting agent of Hillcrest Christian School, the temporary custodian of the minor, whether such diagnosis or treatment is rendered at the office of the licensed physician or dentist, or at a hospital. I/We authorize the physician or dentist to call in any necessary consultants, at his/their own discretion. We further authorize said physician or dentist to exercise his/their discretion in authorizing the disposal of any severed tissues or member.

It is understood that this consent is given in advance of any specific diagnosis or treatment being required, but is given to encourage those persons who have temporary custody of the minor, and said physician or dentist to exercise his/their best judgment as to the requirements of such diagnosis or medical, dental or surgical treatment.

\_\_\_\_\_  
Parent or Guardian Signature Date (\_\_\_\_) \_\_\_\_\_  
Daytime/Emergency Phone

PLEASE RETURN TOP PORTION WITH PAYMENTS BY \_\_\_\_ AND RETAIN BOTTOM PORTION FOR YOUR RECORDS

Student: \_\_\_\_\_ Time Leaving: \_\_\_\_\_ Time Returning: \_\_\_\_\_

Event: \_\_\_\_\_ Date: \_\_\_\_\_

Location Information/ Phone: \_\_\_\_\_

Special Instructions/ what to bring: \_\_\_\_\_