MOUNT HOREB SCHOOL DISTRICT

Field Trip Permission Form

Requesting School: Mt. Horeb Middle School Science Olympiad
Trip Destination: Science Olympiad Regional Competition

Teacher(s): Jennifer Stoddard

Date	Jan. 27, 2017 Saturday	*Time*	4:45 AM to 6:00 PM
Location	UW-Milwaukee		
Cost	None		
Transportation	School District Bus		
Notes	Wear Mt. Horeb Science Olympiad shirt (will be handed out Saturday morning) and comfortable walking shoes/boots. Bring breakfast and snacks to eat or share throughout the day. Lunch (sandwich items: turkey, ham, French bread, chips, fruit) will be provided. Bring any materials/clothing needed for the competition.		

Please return this permission slip by: Tuesday, January 16, 2018

I have reviewed the information regarding this field trip and agree to allow my student to participate. I understand that I am responsible for picking up my student should violations of school/trip rules occur.

I give permission for my Student _____

to attend the field trip to UW-Milwaukee on Saturday, January 27, 2018

Enclosed is $ None to cover the cost of the trip. (Exact cash or check made payable to school.)

Medical Information needed for this trip: (allergies or medical conditions, medications needed, dietary needs or restrictions, etc…)

Emergency Contact Name	Emergency Contact Phone Numbers During Trip

Parent Name _____ Phone _____

Date

Parent/Guardian Signature _____ _____

WISCONSIN SCIENCE OLYMPIAD

CONSENT FOR MEDICAL TREATMENT OF A MINOR

Wisconsin Science Olympiad State, Regional & Invitational Tournaments

School Name: _____

Student Name: _____

NOTE: No competitor will be allowed to compete unless this form is completely filled out and signed by a parent or guardian. We WILL be inspecting all forms at registration.

The Team Coach will keep this form in their possession.

I, _____, BEING THE PARENT OR LEGAL GUARDIAN OF

_____, GRANT THE FOLLOWING AUTHORIZATION FOR MEDICAL AND/OR SURGICAL TREATMENT OF THIS MINOR BY A HEALTH CARE PROFESSIONAL SHOULD THE NEED ARISE WHILE HE/SHE IS ATTENDING THE WISCONSIN SCIENCE OLYMPIAD TOURNAMENT.

I GRANT PERMISSION TO THE COACHES RESPONSIBLE FOR HIS/HER CARE TO ACT ON MY BEHALF FOR SAID MINOR IN GRANTING PERMISSION FOR EVALUATION AND TREATMENT OF MEDICAL OR PSYCHOLOGICAL PROBLEMS. I UNDERSTAND THAT SHOULD A MAJOR MEDICAL OR PSYCHOLOGICAL PROBLEM ARISE, REASONABLE ATTEMPTS WILL BE MADE TO NOTIFY ME BY TELEPHONE. IN THE EVENT THAT I CANNOT BE REACHED, I GIVE MY CONSENT TO SUCH MEDICAL TREATMENT AS DEEMED NECESSARY, INCLUDING SURGERY, X-RAY EXAMINATIONS, AND ANESTHESIA TO BE RENDERED TO SAID MINOR BY A LICENSED PHYSICIAN OR NURSE.

I UNDERSTAND THAT I AM RESPONSIBLE FOR THE COSTS OF TREATMENT. I AUTHORIZE MY INSURANCE COMPANY TO PAY BENEFITS DIRECTLY TO THE HEALTH CARE PROVIDERS. ALSO, I AUTHORIZE THE DISCLOSURE OF MEDICAL INFORMATION TO THE INSURANCE COMPANY FOR THE PURPOSE OF SUBMITTING A CLAIM.

Date _____ Signature of parent/legal guardian _____

Phone # of parent/legal guardian: _(____)_____

Insurance Company: _____

Policy Number: _____

Known medical conditions: _____

This authorization is effective for:
Wisconsin Division C and B 2017-2018 Science Olympiad Sanctioned Tournaments

THIS FORM MUST BE PRESENTED FOR INSPECTION AND CHECK-OFF AT REGISTRATION BEFORE THE COMPETITION.

Note: If a school district also requires and has these forms or similar documentation, these will be accepted at Tournaments