Griffin-Spalding County Schools
Student Activity Permission Form

I. Basic Data

Student Name		
Address		
Phone number for emergency contact		
Activity	Aviation Field Trip	
Date scheduled	Tuesday, February 19th	
Destination and location of activity	Middle Ga. State University	
Cost per child	**Transportation**	Bus
	Admission/Fees	—
	Meals	$10 lunch
	Extra Spending Money	
	Total cost	$10
Educational objectives of the activity/trip	Tour Flight Operations & Maintenance	
Meal plans	Bring $10 for fast food lunch	
Other planned stops on trip		

The undersigned, as natural parent or legal guardian, does hereby consent and grant permission for _____ to participate in the school activity/trip described above.

The undersigned is aware that the student may be exposed to more or greater hazards than may be encountered in attending school. The undersigned shall warn the student of such hazards and caution them to exercise care so as not to contribute to injury or damage to them or others. It is understood that this form must be signed and returned to the school in order for the above named student to participate.

_____ _____

Parent or Guardian Signature **Date**

THIS IS A TWO-SIDED FORM

II. Authorization to Transport

I hereby authorize Griffin-Spalding County School personnel to take my child to the hospital emergency room for treatment. I understand that I am legally responsible for any financial obligations incurred during the emergency treatment.

_____ _____

Name of Parent/Guardian **Date**

III. Authorization for Third Party to Consent to Treatment of Minor Lacking Capacity to Consent

The undersigned, parent(s)/legal guardian of _____, a minor do hereby authorize Griffin-Spalding County School personnel, as agent(s) 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 be rendered under the general or special supervision of, any physician and surgeon duly licensed in the state of Georgia, whether diagnosis or treatment is rendered at the office of said physician or at 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(s) to give specific consent to any and all such diagnosis, treatment, or hospital care which a physician, meeting the requirements of this authorization, may in the exercise of his/her best judgment deem advisable.

The undersigned does authorize emergency personnel to surrender physical custody of such minor to the above named agents upon completion of treatment.

These authorizations shall remain effective until _____, 20_____.

_____ _____

Parent/Legal Guardian **Date**

IV. Emergency Medical Information

In the event the parent/guardian cannot be reached, who should we contact in an emergency?

Name _____ Relationship _____ Phone # _____

Name _____ Relationship _____ Phone # _____

Physician / Phone #: _____

Current Medications: (Dose/Frequency) _____

Previous Surgery: _____

Medical History / Problems (circle all that apply)

Asthma Sickle Cell Migraine Thyroid Kidney Disorder Heart Disease Cancer Diabetes Seizures

ADD/ADHD High Blood Pressure Blood Disorders Hepatitis Bronchitis Religious or Cultural Needs

Parent/Guardian Signature _____ **Date** _____

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