CABELL COUNTY SCHOOLS

SCHOOL FIELD TRIP
Permission for Emergency Medical Treatment

Student Name: Birth Date:

Address:

Social Security Number: Medical Insurance Co.

Policy or Group Number:

Medication Taken Regularly:

Allergies and/or Health Problems:

Contact Person in Case of Emergency: _____

Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Alternate Contact Person: _____

Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

I, being a person authorized by law to give such permission, do hereby give my permission for emergency medical treatment to be given to the person who is the above-named subject of this form. I understand that all reasonable attempts will be made to contact me as soon as possible after the condition necessitating treatment arises, and, that failing, all reasonable attempts to contact the alternate listed above will be made. I understand that all reasonable precautions will be taken for safety at all times.

_____
Signature – Parent or Legal Guardian

STATE OF WEST VIRGINIA,
COUNTY OF _____, TO-WIT,

I, _____, a qualified Notary Public in and for the County aforesaid, herby certify that the person whose signature appears above did, on this date, appear before me, and, after being duly sworn or affirmed, and reading this document in its entirety did affix his or her signature hereto in my presence.

Taken, subscribed, and sworn to before me this _____ day of _____ 20_____.
My commission expires _____ day of _____ 20_____.

_____
Signature – Notary Public