



בית ספר שלום . SHALOM SCHOOL

PERMISSION SLIP FOR OVERNIGHT SCHOOL TRIPS

Student Name: _____ Grade: _____ Teacher: _____

Date: _____ Time: _____

Subject/Event: _____

Location: _____

Special Instructions: _____

Please return this form by: _____

PARENT/GUARDIAN SHOULD INDICATE WHICH ACTION TO BE TAKEN IN THE EVENT OF AN EMERGENCY.

_____ In the event of an emergency when a parent/guardian is unavailable, I hereby authorize a representative of Shalom School to make such arrangements as considered necessary for my child to receive medical or hospital care, including transportation. Under such circumstances, I further authorize the physician named below to undertake such care and treatment as considered necessary. In the event said physician is not available, I authorize such care and treatment to be performed by any licensed physician or surgeon.

Physician's Name _____ Phone Number: _____

Type of Medical Insurance _____ Medical Insurance Number: _____

OR

_____ I do not choose the above. I desire the following action to be taken in the event of an emergency:

The undersigned agrees to bear all costs incurred as a result of the foregoing.

Parent/Guardian Signature: _____ Student's Name: _____

Home Phone _____ Work Phone _____