Version 2-21-2016

Return form to _____

Form Due Date _____

Bixby Public Schools Activity Permission Form

My child, (Student's Name) :_____
Last First Middle

has permission to participate in _____ at _____
Activity Location

Leaving _____ at _____ from _____
Day/Date Time Location

Returning _____ at _____ from _____

Sponsor _____Cost _____

Special Instructions _____

Parent/Guardian/First contact_____ Relationship: _____

Phones: (H)_____(W)_____(cell/other)_____

Parent/Guardian/Second contact_____ Relationship: _____

Phones:(H)_____(W)_____(cell/other)_____

Does your child have any health problems, allergies, or limitations that should be considered for this activity? yes/no (if yes,

please specify)_____

_____

Will your child need medication during this activity trip other than what is given during the normal school day? Yes/No
(if yes, you must supply the medication as directed below and complete the section below *) If your child routinely receives medication while at school, s/he will receive that medication while participating in the school activity unless you specify otherwise.

Name of Medication	Dose/amount	How often?
_____	_____	_____
_____	_____	_____
_____	_____	_____

*Note: Student medications may not be repackaged by school personnel for activity trips. In addition, health services personnel and school supplied medications are not routinely available on activity trips. Therefore, parents/guardians must provide all additional medications needed for the activity trip in properly labeled "original" containers. Medication that has already been supplied to the school will be sent on the activity trip. Health Services personnel will ensure that the medication is given to the staff member designated by the principal to administer medication on the activity trip. Students may not carry or self administer medications on field trips unless previously authorized to do so at school.

Authorization for Treatment

I hereby authorize any physician, surgeon, or dentist on the medical staff of the nearest medical facility to administer any emergency treatment, procedure or medicine necessary and advisable. I also authorize the use of an ambulance, if necessary, to transport my child. I further agree to pay for all services provided for my child. If this is not satisfactory, please list specific emergency instructions in the event that you cannot be reached.

_____

_____

Type name of Parent/Guardian: _____Date _____
THIS IS YOUR DIGITAL SIGNATURE

EMAIL to: BixbyBigEvent@BixbyPS.org or Mail to Freshmen Center, attn: Bob DeCelle, 301 S. Riverview, Bixby Ok 74008