

**DENTON ISD FINE ARTS
PERMISSION TO TRAVEL / MEDICAL RELEASE FORM**

This must be on file with the activity sponsor *before* participating in outdoor activities and
before the student can travel with on any sponsored trips.

(Print student name) _____ has my permission to participate in all Fine Arts program trips for the 2017-18 school year. I release, and hold harmless, Denton ISD, and all its sponsors/staff of all liability in case of an accident on the trips. It is understood that the student is directly responsible to the sponsors in charge of the trip from the time of leaving until returning, the same as if in regular school attendance. Pupils must go and return by the same means of transportation, unless by mutual agreement by the parents and the trip sponsor.

The above named student, and others whose signatures appear below, do hereby consent to any and all medical and surgical treatments, including anesthesia and operations that may be deemed necessary and/or advisable by his/her attending physician and/or surgeons. The intention hereof, being to grant authority to administer and perform all singularly any procedures which may now or during the course of the patient's care be deemed advisable or necessary. I/we also agree that the patient, when admitted, is to remain in the hospital until his/her physician recommends the patient's discharge.

It is understood that the Fine Arts students will be chaperoned both en route and while at any meetings, and that normal precautions will be taken in the interest of the students' safety and well-being. **IN CASE OF INJURY OR ILLNESS, EVERY EFFORT WILL BE MADE TO CONTACT THE PARENT(S) OR GUARDIAN(S) BY TELEPHONE IN ADVANCE OF MEDICAL TREATMENT.**

In witness of our consent, and in agreement to the matters stated in the preceding sentences, we have subscribed our signatures below:

_____ Date: _____ Birth date: ____/____/____
Student/Minor SIGNATURE

_____ Date: _____
Father/Guardian SIGNATURE

_____ Date: _____
Mother/Guardian SIGNATURE

Insurance Company Name*: _____ (leave blank if no insurance)

Policy Number: _____ Group Number: _____

Primary Care Doctor: _____ Doctor's Phone: _____

***PLEASE ATTACH A PHOTOCOPY of PARENT DRIVER'S LICENSE and INSURANCE CARD (if applicable)**

Any and all medication(s) my son/daughter may be allergic to: _____

Food or other substance(s) my son/daughter may be allergic to: _____

Medications my son/daughter is taking: _____

The medication currently being administered is for the treatment of: _____

Does your child have any handicaps/limitations that could hinder any activities? (Circle one) YES NO
(If YES, please describe below. Any special arrangements must be made prior to the activity or trip.)

In the event of an emergency, I can be reached at the following:

Home Phone: _____ Address: _____

Business Phone: _____ Cell Phone: _____ Other Phone: _____

Two individuals who may assume temporary care of your child in the event that you cannot be reached:

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____