APPENDIX 4

STUDENT FIELD TRIP
AUTHORIZATION TO CONSENT TO TREATMENT OF STUDENT

Student's Name _____
(Last) (First)

Home or Emergency Phone No. _____

Address _____

Family Doctor _____

We, the undersigned parent/guardian of the above mentioned student minor do hereby authorize the staff member of Sparta Community Unit District No. 140 supervising the activity concerned, as agent for the undersigned, to consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under general or special supervision of, any physician and surgeon on the medical staff of any licensed hospital whether such diagnosis or treatment is rendered at the office of said physician or at the 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 to give specific consent to any and all such diagnosis, treatment or hospital care which the aforementioned physician in the exercise of his/her best judgment may deem advisable.

Every effort will be made to contact parents or guardians to explain the nature of the problem prior to any involved treatment. This authorization shall remain effective until the end of the school year.

_____ _____
(Date) (Parent/Guardian)

Please list the name of any member of the immediate family that could be contact in case the parent/guardian cannot be reached.

NAME	PHONE	RELATIONSHIP
_____	_____	_____
_____	_____	_____
_____	_____	_____