**CCS[blk]2 Fort Hayes Metropolitan Education Center**

546 Jack Gibbs Boulevard

Columbus, Ohio 43215

Phone (614) 365-6681

Fax (614) 365-6988

www.columbus.k12.oh.us

***­­­­­­­­­­­­­­­­­Mission: Each student is highly educated, prepared for leadership and service, and empowered for success as a citizen in a global community.***

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**FIELD TRIP PERMISSION REQUEST AND AUTHORIZATION**

Date: February 9th, 2018

Dear Parent:

Our 2018 Senior Class is planning a trip to Avalanche Tubing Park at Mad River Mountain

on Saturday, February 17th, 2018 at 10:45 by school bus (or) van.

Will you give your permission for your child/student to accompany us?

Sincerely,

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Staff Signature(s)

I give permission for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to participate in the

above activity.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent Authorization/Signature Date

**Please return this form to the school to Mr. Jeffrey M. Judd by Friday, February 16th.**

**MEDICAL AUTHORIZATION**

Should it be necessary for my son/daughter to have medical treatment during this event, I hereby give the school district or personnel of the destination permission to obtain medical service for my son/daughter. My signature on this form releases the Board of Education of the Columbus City Schools, all district employees, and the personnel of the destination from liability should injury or accident occur while your son/daughter is involved in the event. I also understand that students are not employees of the Columbus Board of Education and they will not be covered by worker’s compensation. **\_\_\_\_\_YES \_\_\_\_\_ NO**

Parent/Guardian’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Please Print Name

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Street Address) (City, State) (Zip Code)

Phone Numbers: Home \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In case of emergency, please call \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family Physician \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_