**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: Monday, February 3rd, 2020

Dear Parent:

Our school is planning a trip to **Avalanche Tubing Park** at Mad River Mountain on **Friday, February 28th 2020 from 3:00 to 8:00 pm** by school bus to build community, celebrate our accomplishments, and support our high school students.

Will you give your permission for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

to accompany us?

Sincerely,

Ms. Wilson and Mr. Judd (Senior Class Advisers)

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

above activity.

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

Parent Authorization/Signature Date

**Please sign the back side of this form and return it to Fort Hayes to Mr. Judd by Friday, February 21st 2020 at the end of the school day.**

**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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_