AD-118a (Revised 05.16.09)

Kokomo-Center Township Consolidated School Corporation

FIELD TRIP

PARENT/LEGAL GUARDIAN PERMISSION

I, being the Father, Mother, or Legal Guardian of (print student's name) _____

a student enrolled in Kokomo High School, hereby consent that he/she may travel to and from (trip or activity) Techno Kats Activities

on a school or commercial bus on date(s) 2016-2017 school year; through July 31, 2017.

I further understand the following:

1. Techno Kats Mentors are the supervisor of this trip.
2. Each bus will have at least one adult chaperone in addition to the driver.
3. Arrangements shall be made for transportation of auxiliary equipment in another vehicle if appropriate storage is not available on student bus.
4. Students who ride a bus to Techno Kats Activities will return to Kokomo on that same bus. Students will not be released to anyone except parent or legal guardian.
5. If any students break school rules and regulations, team expectations, or displays conduct unbecoming a student, their parents will be contacted, and it will become the responsibility of the parent to provide immediate transportation home.

We have read, understand, and will adhere to the above.

Date: _____

Parent or Legal Guardian's Printed Name: _____

Parent or Legal Guardian's Signature: _____

Student's Signature: _____

AD-118B (Revised 05.16.09)

Kokomo-Center Township Consolidated School Corporation

PERMISSION FOR MEDICAL TREATMENT

TO WHOM IT MAY CONCERN:

I, the undersigned, being the parent, or legal guardian of _____,
hereby authorize any necessary medical treatment for the above named student while participating in
(Trip or Activity) Techno Kats Activities, Shop Sessions, or trips.

I guarantee payment of all charges incurred during this medical treatment. *(Physicians, Hospital, X-Ray, Lab, Drugs, Ambulance, etc.)*

In regard to the above name student, I submit the following information:

1. List food allergies, medication allergies, etc (If none, so state): _____
2. List special medical problems (If none, so state): _____
3. Student medication needs: (If none, so state): _____
   Medication (Amount and Frequency) _____
   Purpose: _____
   Medication (Amount and Frequency) _____
   Purpose: _____
   Medication (Amount and Frequency) _____
   Purpose: _____
4. Date of last Tetanus Shot: _____
5. Family Physician: _____ Phone: _____
   Office Address: _____ City: _____ IN, Zip: _____
6. INSURANCE INFORMATION:
   We carry the following type of insurance: (Company) _____
   My insurance is with: (Agent) _____
   My insurance policy number is: (Claim Number) _____

Parent or Legal Guardian Printed Name: _____
Address: _____ City: _____ IN, Zip: _____
Emergency Phone: _____ Mobile Phone: _____ Work Phone: _____

I certify the above information is accurate and complete:

Parent or Legal Guardian Signature: _____ Date: _____