

**St. Mary Catholic Middle School**  
8<sup>th</sup> Grade Field Trip Permission

*If this form is not returned prior to the field trip, the student will not be allowed to go.*

Date	Purpose / Location	Transportation	Cost
9-6-19	8th Grade Retreat-Adventure Park in Suamico	Bus	\$32.00
9/9/19	Library Visits- Neenah & Menasha Public	Bus	0
9/10/19	Library Visits- Neenah & Menasha Public	Bus	0
11/25/19	Library Visits- Neenah & Menasha Public	Bus	0
11/26/19	Library Visits- Neenah & Menasha Public	Bus	0
2/17/20	Library Visits- Neenah & Menasha Public	Bus	0
2/18/20	Library Visits- Neenah & Menasha Public	Bus	0
4/6/20	Library Visits- Neenah & Menasha Public	Bus	0
4/7/20	Library Visits- Neenah & Menasha Public	Bus	0
1/30/20	SMCS ALL Schools CSW Liturgy – SG	Bus	0
2/4/20	All School PAC performance	Bus	\$3.00
6/2/20	8th Grade Retreat Camp Tekakwitha-Shawano	Bus	\$20.00
		<b>Total Due:</b>	<b>55.00</b>

**Please return the bottom portion of this page and payment made to SMCS**

**Student Name:** \_\_\_\_\_

*I hereby request and give permission for my son/daughter to participate on the field trips listed above. He/she is adequately covered by insurance for any injury that he/she might sustain. I have discussed this with my spouse (if appropriate) and we both hereby release St. Mary Catholic Middle School and the persons in charge of these outings from any liability in connection with the same.*

*\*We will accept only this form as permission to participate.*

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Authorization for Medical Treatment**

*I hereby authorize the treatment, administration of anesthesia or surgical treatment for my minor son/daughter \_\_\_\_\_ in the event of a medical situation occurring during my absence or when the hospital or physician(s) are unable to contact me. This authorization extends to any hospital, physician(s), and nursing personnel within the physician's staff. I release from medical responsibility and liability the hospital, physician(s), and nursing personnel for performing medical procedures acting on the authority of this medical treatment consent form which such medical providers deem necessary for my minor child.*

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_