Note: This form must be signed and returned named below is to participate in the field tr	ip or activity.
CONSENT TO PARTICIPATE IN FIELD TE	RIP OR OTHER ACTIVITY AND CONSENT FOR TREATMENT
Date and Nature of Trip:	
Itinerary: 1 All Cen	tre Activities 2023- 2024
Departure Time:	Return Time:
Sponsor(s):	Type of Travel:
Cost to Student:	Other Comments:
I,, the pa	rent/legal guardian of
treatment, including any necessary surgery illness of an emergency nature he/she incu above by any physician or dentist licensed Act, K.S.A. 65-2801, and any hospital.	esentative of <u>Centre School</u> to authorize emergency medical or hospitalization, for my above-named child, for any injury or rred while participating in the field trip or other activity noted in accordance with the provisions on the Kansas Healing Arts sibility for medical and hospital expenses and any emergency
	397 only carries limited secondary insurance coverage.
and/or other charges that are incurred in th of this document shall have the same for medical treatment, I understand that school	e School is not responsible for any medical, hospital expenses e medical treatment or hospitalization of my child. A photocopy ce and effect as the original. If my child requires emergency of personnel will make a reasonable attempt to contact me to nent. To facilitate contacting me, I agree to continue to provide the school.
	covered by USD 397 insurance while at the place of lodging sent in the same room where the student is located.
Health Insurance Provider Name	Parent or Legal Guardian Date
Health Insurance Policy Number	Work Phone Number
	Home Phone Number