CHICAGO WEST SIDE CHRISTIAN SCHOOL FIELD TRIP
MEDICAL TREATMENT / RELEASE FORM

Phone: (773) 542-0663
Fax: (773) 542-0664

Trip: ___________________________

Time: ___________________________

Date: ___________________________

Cost: ___________________________

I, the undersigned parent or guardian, do hereby grant permission for my daughter / son ______________________________ to attend the above mentioned field trip. In order that my child may receive the necessary medical treatment in the event that she/he may sustain injury or illness during the period of the above field trip, I hereby authorize the teacher / chaperone to obtain medical treatment for my daughter / son for such injury or illness, and I hereby hold the teacher / chaperone and Chicago West Side Christian School harmless in the exercise of authority.

I further acknowledge and understand that I will be responsible for any medical bills that may be incurred on behalf of my child for physical illness or injury that she / he may sustain during the above mentioned field trip.

List any allergies the student has, including medicine:

List any medication the student is currently taking:

Phone: Home ______________________

Work ______________________

Pager/cellular phone ______________________

Emergency contact ____
Name phone #

Parent Signature ____ Date:______________