BAND

✓Please sign and return

Deweyville Independent School District
(409) 746-2685 FAX # (409) 746-9343

PERMISSION TO TRAVEL

2024-2025

To Whom It May Concern:

I, ____, parent of

____DOB:___________ Grade:____
(Student Name)

do hereby give my permission for the above named to travel on various school functions in which he/she is involved, during the fiscal year 2024-2025. I, in no way will hold the Deweyville ISD or any sponsor liable for my child's safety or conduct.

In case of an accident or serious illness, I request the school to contact me. If the school is unable to reach me, I hereby authorize the school to call the physician indicated below and to follow his instructions. In the event physicians, other persons on this form, or parents cannot be contacted, the school officials are hereby authorized to take whatever action is deemed necessary in their judgment, for the health of the said child. I will bear the expense of this emergency medical treatment. I will not hold the Deweyville I.S.D. financially responsible for the emergency care or transportation for said child.

If my child is to be transported home, to the hospital, or to the doctor's office, and I cannot arrange for transportation or come for him, the school personnel have my permission to do the above without any liability to the school district personnel.

PHYSICIAN INFORMATION:

Name:____

Telephone Number(s):____

Address:____

INSURANCE INFORMATION:

Policy #:__________________________ Name of Company:________________________

If no insurance check here:__

_____________________________________ ______________________________

SIGNATURE OF PARENT PHONE NUMBER(S)

_____________________________________ ______________________________

ADDITIONAL EMERGENCY CONTACT PHONE NUMBER(S)

***List any medication student is on and pertinent medical information/ allergies in the event of emergency:**

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