Holbrook Seventh-day Adventist Indian School

School Year: _____

2001 McLaws Road • PO Box 910 • Holbrook AZ 86025 • Telephone: (928)524-6845 • Fax: (928) 524-3190 • HISSDA.org

PERMISSION FOR OFF CAMPUS CHAPERONES

School Policy REQUIRES written permission for any adult to take your child off campus for non-school sponsored activities, transportation on home leaves and/or weekends.

I, the parent/guardian of _____, give permission for my child to go off campus with the following ADULT individuals (21years and over):

•Holbrook Indian School Faculty/Staff	**YES NO (Circle one)**	
•Legal Guardians & Parents	**YES NO (Circle one)**	
•The Following Relatives	**Relationship**	**Telephone #**
-		
-		
-		
-		
-		
-		
-		
•Friends of the Family and Others	**Relationship**	**Telephone #**
-		
-		
-		
-		

•I DO NOT GIVE PERMISSION for my child to receive visits on campus from the following•

Name	**Relationship**

***Note**: If the person listed is a parent of the child, a copy of court papers prohibiting this parent access to the child must be on file.

Parent/Guardian _____ Date _____

PERMISSION FOR SPORTS ACTIVITIES AND FIELD TRIPS

I, the parent/guardian of _____, give permission for my child to participate in any/all field trips, sports programs including but not limited to, cross country, volleyball, basketball, skiing, swimming, softball, gymnastics, hiking, backpacking, and rock climbing provided by Holbrook Seventh-day Adventist Indian School. In doing so I waive any legal rights against the school for any injuries which might occur in the _____, school year. However, I do understand that any injury will receive immediate medical attention.

Parent/Guardian

_____

Date _____

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PARENT/GUARDIAN STUDENT DROP OFF INSTRUCTIONS AND WAIVER

Holbrook Seventh-day Adventist Indian School, (HIS) expects that the parent/guardian be present when a student is dropped off at home or any other location. This waiver allows HIS to drop a student off with someone else.

I, the parent/guardian of _____, give permission for the student to be dropped off with the following individuals:

Name	Location	Relationship	Telephone #

By my signature below, I hereby give special permission and represent to HIS that my student may safely be dropped off at

Location: _____

without anyone present. I assume all liability for injuries to my child or third parties that may result from my child being unsupervised after dropping off and release and indemnify HIS for such injuries including its employees, agents, and affiliates.

Parent/Guardian _____ Date _____

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EMERGENCY TREATMENT CONSENT FORM

I, undersigned legal parent/guardian of _____, a minor, do hereby consent to any x-ray, examination (physical or mental), anesthetic, sutures, injections, medical, surgical, mental health diagnosis of/and treatment, and hospital service that may be rendered to said minor under the general or special instructions of any physician or mental health provider the school or organization may call, whether such diagnosis of treatment is rendered at the office of physician, mental health provider, or at licensed hospital.

It is further understood that this consent is given in advance of any specific diagnosis or treatment which might be required and is to authorize HOLBROOK SEVENTH-DAY ADVENTIST INDIAN SCHOOL (HIS) or the physician to exercise their best judgment as to the requirements of such diagnosis or treatment.

The signing of this form shall include authorization for immunization and/or injections for prevention of the disease as required for schools in the state of Arizona and/or Navajo County.

This consent shall remain in continuous effect until revoked in writing. A photo copy of this authorization shall be considered as effective and valid as the original.

We hereby authorize any hospital, physician, or other person who has attended or examined the minor to furnish to any appropriate insurance company, or its representative, the Indian Health Service, the HIS representative, any and all information with respect to any illness, medical history, consultation, prescription, or treatment and copies of all hospital or medical record.

Name of student: _____ Date of Birth: _____

Social Security Number: _____

Allergies: _____ Medications: _____
(ex. Bees, Penicillin…)

Name of Legal Guardian: _____ Relationship: _____

Insurance: _____

Date of Birth: _____

Policy number: _____

Phone (Day): _____

Insured Person: _____

Phone (Evening): _____

I authorize release of medical and mental health information on my child to Pedro L. Ojeda (Principal) as have a need to know.

Legal Guardian Signature: _____ Date: _____

Student Signature: _____ Date: _____

EMERGENCY CONTACT

Name: _____	Relationship: _____
Phone (Day): _____	Phone (Evening): _____