**LINCOLN/SOTA II/COULEE MONTESSORI**
**2018-2019 PARENT AUTHORIZATION FORM**

STUDENT NAME: _____ GRADE: _____

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|---|---|
| _____ _____<br>Student Signature Date<br>_____ _____<br>Parent Signature Date | LINCOLN STUDENT/PARENT HANDBOOK<br>I have read through the Lincoln Student/Parent Handbook on the school website and understand that I responsible for the content. |
| _____ _____<br>Student Signature Date<br>_____ _____<br>Parent Signature Date | DISTRICT CODE OF RIGHTS & RESPONSIBILITIES<br>I have read the District Code of Rights & Responsibilities and understand that I am responsible for the content. |
| _____ _____<br>Parent Signature Date | WALKING FIELD TRIP PERMISSION<br>I hereby give permission for my child to go on field trips within walking distance of Lincoln/SOTA II/Coulee Montessori for the entire 2018-2019 school year. I understand that if I have any special concerns regarding my child participating in field trips I should convey as such in writing to the supervising teacher. If possible, such requests will be honored. It is understood that my child will abide by the instructions given by the supervising teacher. |
| www.lacrosseschools.org/lincoln-middle | SCHOOL WEBSITE<br>Be sure to visit the school website for the school calendar events, news articles, photos, family access link, and important information. |
| _____ | PARENT EMAIL ADDRESS<br>Please provide parent/guardian email addresses. Frequent emails are sent regarding upcoming events and reminders. |

## STUDENT FIELD TRIP/EXTENDED TRAVEL
## AUTHORIZATION TO CONSENT TO MEDICAL TREATMENT OF STUDENT

Student Name: _____ Grade: _____
Home and/or Emergency Phone Numbers: Phone: (___) ___-_____ Phone: (___) ___-_____
Address: _____
Family Doctor: _____ Hospital: _____

(We), the undersigned parent/guardian of the abovementioned student minor do hereby authorize the staff members of the School District of LaCrosse, supervising the activity concerned, as agent for the undersigned, to consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is rendered under general or special supervision of, any physician or surgeon on the medical staff of any licensed hospital whether such diagnosis or treatment is rendered at the office of said physician at the said hospital.

It is understood that this authorization is given in advance of any special diagnosis, treatment, or hospital care being required but is given to provide authority and power on the part of the aforesaid agent to give specific consent diagnosis, treatment, or hospital care which the aforementioned physician in the exercise of his/her best judgment may deem advisable. Also the authorized school district staff person has the authority to call for emergency medical transportation or provide transportation himself/herself, for the benefit of the involved student, as the staff person deems necessary.

Every effort will be made to contact parents/guardians to explain the nature of the problem prior to any involved treatment. This authorization will remain effective for the 2018-2019 school year.

Signature of Parent/Guardian: _____ Date Signed: _____

Please list the names of any members of your immediate family that could be contacted in case the parent/guardian cannot be reached:
Name: _____ Phone: _____ Relationship: _____
Name: _____ Phone: _____ Relationship: _____