

*Chisholm Trail Academy*

401 S. Old Betsy, P.O. Box 717

Keene, TX 76031

(817) 641-6626 ♦ Fax (817) 556-2009

**PARENTAL PERMISSION SLIP – 2008-2009**

**Instructions to the parents: Please complete this form and return it as soon as possible.**

I hereby give permission for my child to participate in the following school activity:

**All practices, activities, and tournaments for girls' and/or boys' volleyball.**

Student's Name: \_\_\_\_\_ Sex: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

Student cell phone number: \_\_\_\_\_ TX, Zip Code: \_\_\_\_\_

**In case of emergency, I hereby give permission for the Chisholm Trail Academy staff to secure proper treatment for my child. Please check if any of the following apply:**

\_\_\_\_ My child needs medication. (Parent is required to furnish medication in the original, properly labeled and correctly authorized container.)

\_\_\_\_ My child is allergic to insect bites to the extent that he/she needs medical treatment.

\_\_\_\_ My child is allergic to: \_\_\_\_\_

\_\_\_\_ My child has special dietary requirements which I have indicated on the back of this form.

\_\_\_\_ My child has other special conditions you should be aware of listed on the back of this form.

Mother's Name: \_\_\_\_\_ Father's Name: \_\_\_\_\_

Mother Home Number: \_\_\_\_\_ Father's Home Number: \_\_\_\_\_

Mother's Work Number: \_\_\_\_\_ Father's Work Number: \_\_\_\_\_

Mother's Cell Phone: \_\_\_\_\_ Father's Cell Phone: \_\_\_\_\_

Alternate Emergency Contact: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Family Physician: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Insurance Coverage Policy: \_\_\_\_\_

I/We are in agreement with and will obey all school rules as announced and/or printed in the school handbook including no drugs, alcohol, or tobacco on this school activity and understand that there are to be no DVD or video players, etc. on the field trip.

Student Signature \_\_\_\_\_ Parent Signature \_\_\_\_\_ Date \_\_\_\_\_