Kiel High School
210 Raider Heights
Kiel, WI 53042

Off Campus Release Form: _____
(Date)

_____has my permission to accompany
(Student's Name)

_____ to _____
(Group or Class) (Destination)

on _____.
(Date)

Departure time: _____ Expected time of return:_____

Student: I acknowledge that I assume all risks in my choice to participate in the above activity. I also assume full responsibility for my actions. I agree to follow all school rules and policies. Further, I will abide by any and all guidelines established by my instructor.

_____ _____
(Student Signature) (Date)

Parent or Legal Guardian:

Person to be reached in case of emergency:_____

Phone number:_____Second number:_____

Special Instructions:_____

I hereby authorize the treatment, administration of anesthesia and surgical treatment(s) for my minor child,

_____, in the event of a medical situation occurring during my
(Child's Name)
absence or when the hospital or physician(s) are unable to contact me. This authorization extends to any hospital and both physician and nursing personnel within the hospital as well as any physician where treatment is rendered in the physician's office. I release from medical responsibility and liability the hospital, medical authorities and physicians fro performing medical procedures acting on the authority of this medical treatment consent form which are deemed necessary for my minor child.

_____ _____
(Signature of Parent or Legal Guardian) (Date)