



# SIMPSON HIGH SCHOOL

P. O. Box 8

4262 Hwy. 8

Simpson, Louisiana 71474

Phone: 337-383-7810 Fax: 337-383-7655



**Ramona Bennett**  
Principal

**Kayla Hopkins**  
Assistant Principal

**Nancy Blalock**  
Counselor

## SCHOOL TRIP PERMISSION FORM AUTHORIZATION FOR MEDICAL TREATMENT

Dear Mrs. Bennett:

I give my word that if I am allowed to attend the trip indicated below that I will abide by all the rules given to me either in writing or verbally pertaining to this trip. I have been informed of these rules and agree that if I break any rule, at any time, I will be sent home immediately at my parent's expense, will lose my membership in the organization I am representing, and will be subject to appropriate disciplinary action by the principal and sponsors, just as if I had broken this rule on the school campus, and will be barred from attending other school trips at any time in the future.

\_\_\_\_\_  
(Signature of Student) Date: \_\_\_\_\_

I hereby grant permission for my son/daughter (named below) to participate in the trip listed below. I understand and/or discussed the rules of this trip with my son/daughter. I relieve the Vernon Parish School Board, Simpson High School faculty and administration and sponsors of this activity of any responsibility for my son/daughter, other than the reasonable and prudent supervision and care from the time of departure until the time of return. I understand and agree that if my son/daughter violates any rule, the advisors will notify me and send my son/daughter home at my expense on the first available means of public transportation.

I further understand that administrators, coaches and other sponsors on school trips and other events sometimes encounter problems in obtaining needed medical treatment of children on these school trips due to lack of authorization by parents. Therefore, please know that sponsors of the school trip or event listed below in which my son/daughter is participating are empowered by me to authorize physicians and medical facilities to administer necessary emergency care and treatment for my son/daughter, the cost of which I will be responsible through funds, insurance programs or other benefits.

\_\_\_\_\_  
(Signature of Parent) Date: \_\_\_\_\_

**AUTHORIZATION FOR:** \_\_\_\_\_  
(Name of Student)

**NAME OF TRIP OR EVENT:** \_\_\_\_\_  
**DATE OF TRIP OR EVENT:** \_\_\_\_\_

### EMERGENCY CONTACT PERSON (S):

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

**Working Together, Reaching for Success, Striving for Excellence at SHS!**  
**Every Child, Every Day, Whatever It Takes!**



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